(29)

No. 84-325-ASX
Status: GRANTED

Title: Metropolitan Life Insurance Company, Appellant
v.
Commonwealth of Massachusetts

Docketed:
August 30, 1984

Court: Supreme Judicial Court
of Massachusetts

Vide:
84-356

Counsel for appellant: Greenfield, Jay

Counsel for appellee: Kelly, Sally A.

Entry	Date	Note	Proceedings and Orders
1	Jul 11 1984		Application for extension of time to docket appeal and order granting same until September 22, 1984 (Brennan, July 12, 1984).
2	Aug 30 1984	G	Statement as to jurisdiction filed.
3	Aug 30 1984		Appendix of appellant Metro. Life Ins. Co. filed.
4	Aug 30 1984		LODGINGS FILED. Vols. I & II of appd. & source bk.
5	Sep 7 1984		Brief amicus curiae of ERISA Industry Comm. filed. VIDED.
6	Sep 29 1984		Brief amicus curiae of Health Insurance Assn. of Amer filed. VIDED.
7	Oct 3 1984		DISTRIBUTED. October 26, 1984
8	Oct 3 1984		REDISTRIBUTED. October 26, 1984
9	Oct 5 1984	X	Motion of appellee Massachusetts to dismiss or affirm filed. VIDED.
10	Oct 18 1984	X	Reply brief of appellant Metro. Life Ins. Co. filed.
11	Oct 29 1984		PROBABLE JURISDICTION NOTED. The case is consolicated with 84-356, and a total of one hour is allotted for oral argument.
			**********
13	Dec 5 1984		Order extending time to file brief of appellant on the merits until December 20, 1984.
14	Dec 10 1984		Brief amicus curiae of Milton R. Hill, et al. filed. VIDED.
15	Dec 20 1984		Brief amicus curiae of Blue Cross and Blue Shield Assn. filed. VIDED.
16	Dec 21 1984		Joint appendix filed. VIDED.
17	Dec 21 1984		Brief of appellant Metro. Life Ins. Co. filed.
18	Dec 21 1984		Brief amicus curiae of AFL-CIO filed. VIDED.
19	Dec 21 1984		Brief amicus curiae of Health Insurance Assn. of America filed. VIDED.
20	Dec 20 1984		Brief amicus curiae of ERISA Industry Comm. filed. VIDED.
21	Dec 21 1984		Brief amicus curiae of National Coordinating Comm. for Multiemployer Plans filed. VIDED.
22	Dec 20 1984		Brief amicus curiae of Internatl. Brotherhood of Electrical Workers #421, et al filed. VIDED.
23	Dec 28 1984		Brief amicus curiae of American Chiropractic Assn. filed.
24	Dec 31 1984		Record filed.
25	Jan 2 1985	D	Motion of American Chiropractic Association for leave to participate in oral argument as amicus curiae in No. 84-325, for divided argument and for additional time filed.
26	Jan 3 1985	G	Motion of appellants for divided argument filed.
27	Jan 4 1985		SET FOR ARGUMENT. Tuesday, February 26, 1985. This case is consolidated with No. 84-356. (3rd case) (1 hr.).
28	Jan 8 1985		Opposition of respondent to motion of American Chiropractic

No. 84-325-ASX

Entry	Date	Note	Proceedings and Orders
			Association for leave to filed.
29	Jan 14 1985		Motion of American Chiropractic Association for leave to participate in oral argument as amicus curiae in No. 84-325, for divided argument and for additional time DENIED. Justice Powell OUT.
30	Jan 14 1985		Motion of appellants for divided argument GRANTED. Justice Powell OUT.
31	Jan 15 1985		Brief amicus curiae of American Optometric Assn. filed. VIDED.
32	Jan 17 1985		Appellee Massachusetts received appellants' brief on merits 12/26/84; its brief due 1/25/85.
33	Jan 23 1985		Brief amicus curiae of Natl. Assn. of Alcholism Treatment Programs filed. VIDED.
34	Jan 24 1985		Brief amicus curiae of Comm. for Comprehensive Insurance Coverage filed.
35	Jan 24 1985		Brief amicus curiae of Connecticut, et al. filed. VIDED.
36	Jan 25 1985		Brief amicus curiae of American Psychiatric Assn., et al. filed.
37	Jan 25 1985		Brief amicus curiae of American Psychological Assn., et al. filed. VIDED.
38	Jan 28 1985		CIRCULATED.
39	Jan 25 1985	X	Brief of appellee Massachusetts filed. VIDED.
40	Jan 25 1985	X	Brief amicus curiae of Natl. Conference of State Legislatures, et al. filed.
41	Jan 25 1985	X	Brief amicus curiae of Oregon filed. VIDED.
42	Jan 25 1985	X	Brief amicus curiae of American Public Health Assn., et al. filed. VIDED.
43	Feb 19 1985	X	Reply brief of appellant Metro. Life Ins. Co. filed.
44	Feb 26 1985		ARGUED.

84-325

No.

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CLERK

In the Supreme Court of the United States

OCTOBER TERM, 1983

METROPOLITAN LIFE INSURANCE COMPANY, APPELLANT

v.

COMMONWEALTH OF MASSACHUSETTS

ON APPEAL FROM THE SUPREME JUDICIAL COURT FOR THE COMMONWEALTH OF MASSACHUSETTS

JURISDICTIONAL STATEMENT

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QUESTION PRESENTED

Whether a state statute that requires insured employee benefit plans to provide specified minimum benefits for certain kinds of medical services is preempted by Section 514(a) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1144(a).*

---

* Metropolitan Life Insurance Company and the Travelers Insurance Company were the appellants in the Supreme Judicial Court of Massachusetts. Travelers will also docket an appeal to this Court and will discuss preemption under the National Labor Relations Act, 29 U.S.C. 151 *et seq.* Metropolitan joins in Travelers' arguments concerning the NLRA and incorporates them by reference in this jurisdictional statement.

In accordance with Rule 28.1 of the Rules of this Court, Metropolitan states that, other than wholly-owned subsidiaries, it has only one subsidiary in which it owns a controlling interest of more than 50%. That subsidiary is Dawn Water Company.

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In the Supreme Court of the United States

OCTOBER TERM, 1983

No.

METROPOLITAN LIFE INSURANCE COMPANY, APPELLANT

v.

COMMONWEALTH OF MASSACHUSETTS

ON APPEAL FROM THE SUPREME JUDICIAL COURT FOR THE COMMONWEALTH OF MASSACHUSETTS

JURISDICTIONAL STATEMENT

This case is already familiar to the Court. On July 6, 1983, the Court vacated the 1982 judgment of the Supreme Judicial Court of Massachusetts and remanded for reconsideration in light of *Shaw* v. *Delta Air Lines*, 103 S. Ct. 2890 (1983). In April 1984, a majority of the Supreme Judicial Court adhered to its earlier decision, notwithstanding the ruling in *Shaw* and this Court's decision in *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981). Accordingly, appellant once again seeks review here.

OPINIONS BELOW

The April 1984 opinion of the Supreme Judicial Court of Massachusetts (App. A, 1a-8a)[1] is reported at 391 Mass. 730 and 463 N.E.2d 548. The earlier opinion of

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[1] "App." refers to the separately bound appendix filed jointly in this Court by appellant and The Travelers Insurance Company.

that court (App. D, 13a-34a) is reported at 385 Mass. 598 and 433 N.E.2d 1223. The findings and conclusions of the state trial court (App. F, 36a-62a) are not reported. The trial court's opinion on appellee's motion for preliminary injunctive relief (App. I, 71a-84a) is not reported.

JURISDICTION

The judgment of the Supreme Judicial Court of Massachusetts (App. B, 9a) was entered on April 25, 1984. A notice of appeal to this Court (App. K, 93a-94a) was filed on May 29, 1984. On July 12, 1984, Justice Brennan extended the time for docketing the appeal to September 22, 1984 (Appendix, *infra*). The jurisdiction of this Court is invoked under 28 U.S.C. 1257(2).

STATUTORY PROVISIONS INVOLVED

Section 47B of Massachusetts General Laws Chapter 175 and the relevant provisions of the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001 *et seq.*, are reprinted in App. J, 85a-89a.

STATEMENT

In 1974, after extended study, Congress enacted the Employee Retirement Income Security Act ("ERISA") to protect the interests of participants in employee benefit plans and to enable such plans to be administered on a uniform, nationwide basis. To achieve these goals, Congress sought to occupy the regulatory field fully and thereby to eliminate the problems caused by diverse, patchwork state legislation. In Section 514(a) of ERISA, 29 U.S.C. 1144(a), Congress explicitly preempted all state laws that regulate, directly or indirectly, employee benefit plans covered by the federal statute. In unmistakable terms, Section 514(a) provides that the federal law "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan * * *."

In 1973, shortly before the enactment of ERISA, the Massachusetts legislature passed the "mandated benefit" statute at issue in this case. The state law, Section 47B of Massachusetts General Laws Chapter 175, requires, among other things, that employee health and welfare plans and insurance policies sold to such plans provide certain specified minimum benefits for the care of mental and nervous conditions.[2] Section 47B became effective on a mandatory basis on January 1, 1976.

Massachusetts has not sought to enforce Section 47B to the extent it applies directly to employee benefit plans. The Commonwealth concedes that ERISA precluded state legislatures from directly prescribing the nature and level of benefits that must be provided by plans covered by the federal law (App. F, 43a, 59a). But, the Commonwealth maintains, health insurance policies purchased by such plans must abide by the requirements of Section 47B and provide the specified coverage for mental and nervous conditions to plan beneficiaries residing in Massachusetts. Accordingly, in the Commonwealth's view, all insured employee health and welfare plans must offer the particular benefits mandated by the state legislature, even though ERISA bars the legislature from imposing that requirement directly on the plans themselves.

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[2] In particular, Section 47B requires that employee benefit plans and health insurance policies satisfy the following minimum requirements (App. J, 88a-89a):

> "(a) In the case of benefits based upon confinement as an inpatient in a mental hospital under the direction and supervision of the department of mental health, or in a private mental hospital licensed by the department of mental health, the period of confinement for which benefits shall be payable shall be at least sixty days in any calendar year.
>
> "(b) In the case of benefits based upon confinement as an inpatient in a licensed or accredited general hospital, such benefits shall be no different than for any other illness.
>
> "(c) In the case of outpatient benefits, these shall cover, to the extent of five hundred dollars over a twelve-month period, services furnished [by persons or institutions having certain specified qualifications]."

Both appellant Metropolitan Life Insurance Company and The Travelers Insurance Company have issued numerous health insurance policies to employee benefit plans.[3] Following the enactment of ERISA, Metropolitan and Travelers concluded that, in light of the preemption provision in the federal statute and the Supremacy Clause in Article VI of the federal Constitution, the mandatory feature of Section 47B could not properly be applied to employee benefit plans or to the health insurance policies they purchase. For this reason (among others), Metropolitan and Travelers did not modify certain of their employee benefit plan policies to include the minimum coverage required by Section 47B, and they continued to pay benefits under those policies in accordance with the plan and existing policy terms.

On June 1, 1979, the Commonwealth filed this action for declaratory and injunctive relief in the Superior Court for Suffolk County, Massachusetts. The Commonwealth sought (i) a declaration that Section 47B can validly be applied to insured ERISA plans and (ii) an injunction directing Metropolitan and Travelers to comply with the state statute. On the Commonwealth's motion, the trial court entered a preliminary injunction requiring defendants to provide the benefits mandated by Section 47B to Massachusetts residents covered by insurance policies issued or renewed by defendants after January 1, 1976 (App. I, 71a-84a).

At trial, defendants stressed that state mandated benefit statutes, such as Section 47B,

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[3] Among other ERISA plans covered by Metropolitan policies is General Electric Company's employee health insurance plan, which provides coverage to approximately one million persons nationwide. General Electric has, for many years, observed a uniform benefits policy for all plan members. A. 135-136. ("A." refers to the Appendix filed in the Supreme Judicial Court, together with the parties' opening briefs, in August 1981. A copy of the Appendix has been lodged with the Clerk of this Court.)

(i) make uniform ERISA plans covering employees in different states far more difficult to achieve;

(ii) significantly increase the cost of plan administration; and

(iii) force plan participants and plan sponsors to choose among (a) paying higher premiums to defray the additional cost of the new, mandated benefit; or (b) sacrificing other benefits that are already covered by the plan and that may well be more desirable than the mandated benefit; or (c) forgoing insurance altogether.

Defendants also observed that mandated benefit statutes improperly tend to encourage insured employee benefit plans to drop their insurance and become self-insurers. State statutes like Section 47B, when applied only to insured plans, ascribe significance to a distinction not drawn by Congress, *i.e.*, the distinction between insured and non-insured plans; they penalize insurance and thus threaten the financial security of ERISA plans.

Notwithstanding these arguments, the Superior Court sustained the validity of Section 47B and granted the injunction sought by the Commonwealth (App. F, 36a-62a). The court stated merely that Section 47B "is not preempted by * * * ERISA" (*id.* at 57a).

On direct appeal, the Supreme Judicial Court of Massachusetts affirmed (App. D, 13a-34a). The court noted that, in addition to the broad preemption provision in Section 514(a), ERISA also contains a "savings clause" for state insurance regulation (*id.* at 18a). Section 514(b)(2)(A) of the Act provides that nothing in the statute "shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." 29 U.S.C. 1144(b)(2)(A).[4]

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[4] Section 514(b)(2)(B), in turn, qualifies the savings clause. It states:

> Neither an employee benefit plan * * * nor any trust established under such a plan, shall be deemed to be an insurance

Although the Commonwealth argued that Section 47B "regulates insurance" and therefore is automatically exempt from ERISA preemption, the court was unwilling to adopt this simplistic contention. Indeed, the court stated (App. D, 21a):

> We are wary of such a literal reading, which might permit the State, through its insurance laws, to reach far into areas governed by ERISA, and thereby negate the unmistakable intent of Congress to work a broad preemption.

The court accepted the Commonwealth's argument only to the extent of acknowledging that "the language of the savings clause is broad enough to *permit* a construction that would exempt § 47B from preemption" (*id.* at 21a-22a; emphasis added).

As stated in its original decision, the Supreme Judicial Court's principal reason for upholding Section 47B was that the state law deals with the "substantive content" of employee benefits plans, not with the conduct of plan administrators. The court explained (App. D, 22a; citations and footnote omitted):

> Congress, when it enacted ERISA, was concerned with widespread abuses in plan administration, often resulting in employees' losses of anticipated benefits. In response, Congress enacted rules governing disclosure and fiduciary conduct by administrators of welfare benefit plans. Section 47B has no bearing on the problem of administrative abuse, and does not overlap or interfere with the means chosen by Congress to deal with such abuse. Section 47B affects only the substantive content of plans—a subject completely untouched by ERISA's regulatory provisions. Therefore, nothing in the practical relationship between the two statutes calls for an implied limitation on the phrase "regulates insurance" that would exclude § 47B from the protection of the savings clause.

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company or other insurer, * * * or to be engaged in the business of insurance * * * for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts * * *.

The court thus believed that questions of ERISA preemption ultimately can be determined only by considering the extent of actual practical conflict between federal and state law.

Metropolitan and Travelers appealed to this Court, contending that the Massachusetts court erred in permitting its preemption decision to turn on the asserted lack of conflict between Section 47B and the substantive regulations in ERISA. This Court vacated the judgment of the Massachusetts court (App. C, 10a-12a), and remanded for reconsideration in light of *Shaw* v. *Delta Air Lines*, 103 S. Ct. 2890 (1983). *Shaw* held that ERISA preemption is broad and does not depend on the existence of conflict between a state statute and federal regulatory provisions. 103 S. Ct. at 2900.

On remand, the Supreme Judicial Court adhered to its earlier decision and rationale (App. A, 1a-8a). The court acknowledged that this Court might reach a different result, but it "decline[d] to anticipate such a ruling" (*id.* at 4a). The state court refused to accept *Shaw*'s plain statement that the exceptions to ERISA preemption are "narrow." Instead, it labeled that aspect of the *Shaw* opinion "dictum" and sought to distinguish between the "exemption" from ERISA coverage considered in *Shaw* and the "exception" to ERISA preemption found in the insurance savings clause (*ibid.*).

The Massachusetts court conceded that this Court in *Shaw* rejected the argument that ERISA's broad preemption provision preempts only those state laws that actually conflict with ERISA's substantive regulations (App. A, 5a). Nevertheless, the state court held, such a "conflict-based analysis" is appropriate for interpreting the insurance savings clause (*ibid.*).

The Massachusetts court acknowledged *Shaw*'s holding that, in enacting ERISA, Congress intended to encourage uniform interstate employee benefit plans and therefore chose to preempt conflicting and inconsistent state and local regulations (App. A, 5a-6a). The court held, however, that this congressional intent "is inconsistent * * * with the broad language of the insurance exception" (*id.* at 6a). Accordingly, the court refused to change its earlier decision and expressly ruled that a state can "mandate employee benefits indirectly through its insurance laws" (*ibid.*).

Justice Wilkins dissented. He took the position that, under *Shaw*, the exceptions to ERISA preemption should be read narrowly, lest a multistate employer be denied the opportunity to maintain a uniform ERISA plan (App. A, 8a). Justice Wilkins concluded that Section 47B is not a law that "regulates insurance" within the meaning of ERISA's savings clause. Rather, the dissenting justice wrote, "Section 47B represents precisely that form of local intrusion on ERISA covered benefit plans that ERISA intends to prevent" (*ibid.*).

THE QUESTION IS SUBSTANTIAL

This case presents an important question concerning the operation of employee health plans. A large number of states have now enacted statutes that require health insurance policies available to such plans to include particular benefits for particular medical conditions.[5] The

[5] At least 12 states, including Massachusetts, now have mandated benefit statutes like Section 47B, requiring coverage of mental health services. Colo. Rev. Stat. § 10-8-116(7) (Supp. 1983); Conn. Gen. Stat. Ann. § 38-174d (West Supp. 1984); Me. Rev. Stat. Ann. tit. 24-A, § 2843 (West Supp. 1983-1984); Md. Ann. Code art. 48A, § 477E (Michie Supp. 1983); Mass. Gen. Laws Ann. ch. 175, § 47B (West Supp. 1984-1985); Minn. Stat. Ann. § 62A.151 (West Supp. 1984); Mont. Code Ann. §§ 33-22-701 to -704 (1983); N.H. Rev. Stat. Ann. § 415:18-a (1983 & Supp. 1983); N.D. Cent. Code § 26-39-03 to -04 (1978); Ore. Rev. Stat. § 743.558 (as amended by 1983 Ore. Laws ch. 601, § 6); Va. Code § 38.1-348.7 (1981); Wis. Stat. Ann. § 632.89 (West 1980 & Supp. 1983-1984).

At least 20 states have statutes requiring that benefits be provided for the treatment of alcoholism and, in some instances, drug abuse. Conn. Gen. Stat. Ann. § 38-262b (West Supp. 1984); Ill. Ann. Stat. ch. 73 § 979(8) (Smith-Hurd Supp. 1984-1985); Ky. Rev. Stat. Ann. § 304.18-160 (1981); Me. Rev. Stat. Ann. tit. 24-A, § 2842 (West Supp. 1983-1984); Md. Ann. Code art. 48A, § 490F (Michie Supp. 1983); Mass. Gen. Laws Ann. ch. 175, § 110(H) (West Supp. 1984-1985); Mich. Comp. Laws Ann. §§ 500.3425, 500.3609a(2) (West 1983); Minn. Stat. Ann. § 62A.149 (West Supp. 1984); Miss. Code Ann. § 83-9-27 (Supp. 1983); Mo. Ann. Stat. § 376.779 (Vernon Supp. 1983); Mont. Code. Ann. §§ 33-22-701 to -704 (1983); Nev. Rev. Stat. §§ 689B.030, 689B.036 (1983); N.J. Stat. Ann. § 17B.27-46.1 (West 1984); N.D. Cent. Code § 26-39-03 to -04 (1978); Ohio Rev. Code Ann. § 3923.29 (Page Supp. 1983); Ore. Rev. Stat. § 743.557 (as amended by 1983 Ore. Laws ch. 601, § 5); R.I. Gen. Laws § 27-38-1 (Michie Supp. 1983); Va. Code § 38.1-348.7(A) (1981); Wash. Rev. Code Ann. §§ 48.21.170, 48.21.180 (West Supp. 1984-1985); Wis. Stat. Ann. § 632.89 (West 1980 & Supp. 1983-1984).

Other mandated benefit statutes concern home health care, reconstructive surgery, and various other medical services. See, *e.g.*, Ariz. Rev. Stat. Ann. § 20-1402(4)(b) (West Supp. 1983-1984) (home health care); Nev. Rev. Stat. § 689B.030(6) (1979) (hospice care); N.J. Stat. Ann. § 17B:27-46.1a (West 1984) (reconstructive surgery following mastectomy); Wis. Stat. Ann. § 632.895(4) (West Supp. 1983-1984) (inpatient and outpatient care for kidney disease).

number of employees and dependents potentially affected by such statutes is enormous. (As already noted, one ERISA plan alone, the General Electric plan, has approximately one million beneficiaries. See page 4, note 3, *supra*.) Mandated benefit statutes like Section 47B undercut one of the primary congressional purposes in enacting ERISA—encouraging uniformity of coverage in plans covering employees in several states. The compatibility of ERISA with such laws therefore is an issue that deserves the attention of this Court.

The decision of the Supreme Judicial Court is inconsistent with both of this Court's leading decisions on

ERISA preemption, *Shaw* v. *Delta Air Lines*, 103 S. Ct. 2890 (1983), and *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981). These cases establish that ERISA's preemption provision is broad, that the exceptions to preemption are narrow, and that the states may not indirectly regulate the terms of an ERISA plan. The Massachusetts court has failed to apply these principles.

Shaw holds that the scope of ERISA preemption does not depend on the existence of an actual conflict between a state law and ERISA's substantive provisions. Notwithstanding this holding, and notwithstanding this Court's remand for reconsideration in light of *Shaw*, the Massachusetts court adhered to its earlier decision, insisting that the lack of any conflict with ERISA's substantive provisions precludes preemption of Section 47B.

The ruling below permits Massachusetts to achieve indirectly, through a purported regulation of insurance, a result that it could not achieve directly, namely, the prescribing of benefits that must be provided by insured ERISA plans. The decision thus runs directly counter to the holding in *Alessi*, which refused to allow the states to regulate ERISA plans indirectly, through legislation ostensibly intended for another purpose.

The Supreme Judicial Court declined to find Section 47B preempted, even though it recognized the "intimations in *Shaw*" that this Court "would reach a different result" (App. A, 4a). This Court should now grant review to correct the error of the Massachusetts court and establish the proper relationship between ERISA and state mandated benefit statutes.

A. ERISA Preemption is Broad and Does Not Depend on Conflict with ERISA's Substantive Provisions

Shaw stressed the breadth of ERISA's preemption of all state laws that "relate to" employee benefit plans. The Court observed that "[t]he breadth of § 514(a)'s pre-emptive reach is apparent from that section's lan-

guage" (103 S. Ct. at 2899-2900). Moreover, the Court said, the legislative history of Section 514(a) demonstrates that "Congress used the words 'relate to' * * * in their broad sense" (*id.* at 2900). The Court noted that the congressional conference committee that considered the bill that became ERISA deliberately broadened the bill's preemption provision to make clear that the provision's applicability is not limited to state laws relating to the specific subjects covered by ERISA. The committee's report "indicated that the section's preemptive scope was as broad as its language" (*id.* at 2901, citing H. R. Conf. Rep. No. 93-1280, 93d Cong., 2d Sess. 383 (1974)). In addition, as the Court recognized, the bill's sponsors in both the House and the Senate went out of their way to stress the importance and the breadth of ERISA's preemption provision. See 103 S. Ct. at 2901 and n.20, quoting 120 Cong. Rec. 29197 (1974) (remarks of Rep. Dent); *id.* at 29933 (remarks of Sen. Williams); *id.* at 29942 (remarks of Sen. Javits).

Shaw thus confirmed this Court's earlier conclusion in *Alessi* that Congress "meant to establish [employee benefit] plan regulation as exclusively a federal concern" (451 U.S. at 523). Congress sought to occupy the regulatory field fully and to leave no room for supplementary state regulation. See also, *e.g.*, *Azzaro* v. *Harnett*, 414 F. Supp. 473, 474 (S.D.N.Y. 1976), aff'd, 553 F.2d 93 (2d Cir.), cert. denied, 434 U.S. 824 (1977); *Hewlett-Packard Co.* v. *Barnes*, 425 F. Supp. 1294, 1299-1300 (N.D. Cal. 1977), aff'd, 571 F.2d 502 (9th Cir.), cert. denied, 439 U.S. 831 (1978); *National Carriers' Conference Committee* v. *Heffernan*, 454 F. Supp. 914, 917 (D. Conn. 1978). As Judge Newman has written,

> Congress made a clear-cut decision not to identify various subjects on which state laws were to be preempted, but instead sought to avoid constant litigation over the scope of preemption by preempting, with certain specific exceptions, "all" state laws in-

> sofar as they "related" to plans covered by ERISA.
> * * *
>
> * * * § 514(a) preempts all state laws that relate to covered plans, whether the relation arises because a state law is specifically designed to affect such plans or because, as in this case, a state law of general application includes covered plans within its sweep.

Pervel Industries v. *Connecticut Commission on Human Rights and Opportunities*, 468 F. Supp. 490, 492 (D. Conn. 1978), aff'd, 603 F.2d 214 (2d Cir. 1979), cert. denied, 444 U.S. 1031 (1980).

Shaw recognized not only that ERISA preemption is broad but also that the exceptions to preemption are narrow. Quoting again the congressional sponsors of ERISA, the Court observed that "Congress applied the principle of pre-emption 'in its broadest sense to foreclose any non-Federal regulation of employee benefit plans,' creating *only very limited exceptions* to pre-emption" (103 S. Ct. at 2903, quoting 120 Cong. Rec. 29197 (remarks of Rep. Dent); emphasis added). Similarly, the Court referred to "the combination of Congress' enactment of an *all-inclusive pre-emption provision* and its enumeration of *narrow, specific exceptions* to that provision" (*ibid.*; emphasis added).

To be sure, *Shaw* was concerned directly with statutory provisions other than the insurance savings clause in Section 514(b)(2)(A) of ERISA.[6] But that does not mean, as the Massachusetts court asserted, that the Court's reference to the narrowness of the exceptions to

[6] In particular, *Shaw* construed Section 514(d) of ERISA, 29 U.S.C. 1144(d), which provides that nothing in the statute shall "be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States," and Section 4(b)(3) of ERISA, 29 U.S.C. 1003(b)(3), which exempts from coverage under the federal law "any employee benefit plan * * * maintained solely for the purpose of complying with applicable * * * disability insurance laws."

ERISA preemption was dictum. Nor does it provide any justification for the Supreme Judicial Court's proposed distinction between "exemptions" from ERISA coverage and "exceptions" to ERISA preemption (App. A, 4a).

According to the Massachusetts court, the only exceptions to ERISA preemption are contained in Section 514(b), and this Court did not construe that provision in *Shaw* (App. A, 4A). Rather, the Massachusetts court said, this Court focused on the exemption from ERISA coverage in Section 4(b)(3) and the provision in Section 514(d) that preserves federal law. In the view of the Massachusetts court, neither of these provisions creates an exemption to ERISA preemption. The Supreme Judicial Court ruled that, although the "exemption" at issue in *Shaw* is to be construed narrowly, the "exceptions" provided by Section 514(b), including the insurance savings clause, are to be construed broadly.

The distinction proposed by the Massachusetts court is seriously flawed. Both "exemptions" from ERISA coverage and "exceptions" to ERISA preemption have the same effect; they define the limited areas of permissible state regulation of employee benefit plans. This Court in *Shaw* reviewed the entire statutory scheme and concluded that ERISA's broad preemption contemplates only a few narrow exceptions. 103 S. Ct. at 2899-2906. The Court specifically spoke in terms of "exceptions" (*id.* at 2899, 2902, 2903); it did not attach any significance to the semantic distinction pressed by the Massachusetts court.

This Court's analysis of the breadth of ERISA preemption and the narrowness of the exception to that preemption was an integral part of the reasoning that led to the Court's holding with respect to the New York Human Rights Law in *Shaw*. Far from dictum, the portions of the *Shaw* opinion quoted above represent this Court's definitive assessment of the interaction between ERISA's preemption provision and the limited number of qualifications created by Congress.

Shaw squarely holds that the preemption provision in Section 514(a) of ERISA cannot "be interpreted to preempt only state laws dealing with the subject matters covered by ERISA—reporting, disclosure, fiduciary responsibility, and the like" (103 S. Ct. at 2900). As Justice Wilkins correctly wrote in dissent below, "Congress has adopted an all-inclusive preemption scheme, and it is now clear, in light of the *Shaw* opinion, that it is irrelevant whether State law dictating plan benefits conflicts with the substantive policies of ERISA" (App. A, 8a).

As Justice Wilkins recognized, the decision of the Massachusetts court cannot be reconciled with the holding in *Shaw*. The Massachusetts court incorrectly allowed its decision to be determined by the lack of any actual conflict between Section 47B and the substantive regulations of ERISA. That is not the appropriate inquiry under *Shaw*. It is no more proper where the insurance savings clause is involved than where other exceptions to ERISA preemption are at issue. Rather than looking for conflict with ERISA's regulatory provisions, the Massachusetts court should have focused on the effect of Section 47B, and of mandated benefit statutes generally, on insured ERISA plans.

The narrow exception in Section 514(b)(2)(A) for state laws regulating insurance was not intended to permit states to prescribe the benefits to be provided by insured ERISA plans. Congress chose both to occupy the regulatory field for ERISA plans and to leave to the plans' discretion the kinds of benefits to be provided. *Shaw* explicitly recognized that "ERISA does not mandate that employers provide any particular benefits" (103 S. Ct. at 2897). It would be inconsistent with this legislative choice to permit states, in the guise of regulating insurance, to dictate the benefits that insured ERISA plans must provide.

The savings clause for state laws regulating insurance was intended to permit states to continue their traditional function of regulating the solvency and business practices of insurance companies. It was never intended to authorize the states to undertake a kind of regulatory activity that Congress itself deliberately eschewed. *Michigan United Food & Commercial Workers Unions & Food Employers Health & Welfare Fund* v. *Baerwaldt*, 572 F. Supp. 943 (E.D. Mich. 1983), appeal docketed, No. 83-1570 (6th Cir. Aug. 16, 1983). (As we discuss in greater detail at pages 24-25, *infra*, such a construction gives vitality both to the savings clause and to ERISA's broad preemption of state law.)

B. In Disregard of this Court's Holding in *Alessi*, the Decision Below Would Permit States to Do Indirectly What They May Not Do Directly

Alessi held that ERISA's Section 514(a) is broad enough to preempt even state laws that do not directly regulate employee pension or welfare plans. In invalidating a New Jersey workers' compensation law, the Court said that "even indirect state action bearing on private pensions may encroach upon the area of exclusive federal concern" (451 U.S. at 525).[7]

Here, Massachusetts plainly intended to regulate the content of employee benefit plans. Materials prepared by the Massachusetts legislature in connection with Section 47B show that the statute's purpose was to make mental health care more readily available to all state residents, and to increase the revenues recoverable by the Commonwealth for that care. General Court Joint Committee on Insurance, *Advances in Health Insurance in Massachusetts* (August 1974), summarized in App. F, 52a-53a. The statutory provision governing health insurance policies was merely one means to that end; the Commonwealth was seeking to improve access to mental health care, not to regulate insurance.

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[7] The New Jersey statute at issue in *Alessi* prohibited the setoff of workers' compensation payments against employees' retirement pension benefits payable under ERISA plans.

Section 47B is addressed explicitly to employee benefit plans, not merely to insurance policies. ERISA, of course, compelled the Commonwealth to concede that Section 47B cannot be applied directly to employee benefit plans, but that does not change the fundamental character of the legislation. As the statutory language shows, Section 47B was intended to regulate the plans themselves.[8] By defending Section 47B now as an insurance statute, the Commonwealth seeks to justify state control over the

[8] In defending Section 47B as "a bona fide regulation of insurance," the Supreme Judicial Court asserted that "a large proportion" of the insurance policies to which the statute applies are unrelated to employee benefit plans (App. A, 7a). Even if the court's assertion was intended to refer solely to mere numbers of policies, it is not supported by the record. The parties stipulated and the trial court found that "[t]he preponderance of insurance policies affected by [Section 47B] have been issued to employers" (App. F, 43a).

If the court's remark was intended to refer to the far more meaningful criteria of number of persons covered, amount of premiums paid, and amount of benefits distributed, it is simply inaccurate. Measured by any of the latter criteria, group health insurance policies (principally policies sold to ERISA plans) far outweigh individual policies.

For calendar year 1981 (the latest year for which data are available), nationwide industry statistics show that nearly 116 million persons were covered by group "major medical" policies, while only 6.6 million persons were covered by individual "major medical" policies. The figures for basic hospital insurance and insurance for surgical and physician's expenses are comparable. Also in 1981, the total nationwide medical insurance premiums paid for group policies were approximately $37 billion; the total premiums paid for individual policies were only $4.7 billion. Similarly, the total benefits distributed under group medical policies in 1981 were more than $30 billion; the total benefits distributed under individual policies were under $3 billion. Health Insurance Association of America, *Source Book of Health Insurance Data* 14-27 (1982-1983). (A copy of this reference pamphlet has been lodged with the Clerk of the Court.)

There is no reason to believe that the relative significance of group and individual policies in Massachusetts varies substantially from the nationwide picture.

benefits provided by insured plans. The Commonwealth is thus trying to accomplish indirectly what it cannot accomplish directly. That is exactly what this Court refused to permit in *Alessi*.

If the position of the Massachusetts court were to prevail, the significance of ERISA's preemption provision would be drastically reduced, and the congressional intent underlying Section 514(a) would be defeated. By purporting to "regulate insurance," and thereby indirectly, but effectively, regulating employee benefit plans, states could achieve the very ends that Congress has foreclosed.

Indeed, with respect to insured plans, the Commonwealth's argument here means that the result reached in *Alessi* could actually be reversed through action by a state legislature. A state law could require that any insurance policy covering an employer's workers' compensation obligations contain a provision forbidding the offset of benefits payable under that policy against benefits due to an employee under a retirement or pension plan. Under the reasoning of the Supreme Judicial Court, such a state law would not be preempted by ERISA, even though it would accomplish precisely the result found unacceptable by this Court in *Alessi*.

Because Massachusetts cannot directly compel ERISA plans to provide specific health benefits—a point the Commonwealth concedes—it should not be permitted to achieve that result indirectly. As this Court wrote in *Alessi* (451 U.S. at 525), "ERISA's authors clearly meant to preclude the States from avoiding through form the substance of the pre-emption provision."

C. Several Important Practical Considerations Militate Against the Result Reached Below

1. *Congress sought to encourage uniformity in multistate plans*

The legislative history of ERISA shows that Congress chose the broad preemption approach to foster uniformity and stability of employee benefit plans and to eliminate the threat of conflicting and inconsistent state regulation. For example, during floor debate in the House, Representative Dent, Chairman of the Subcommittee on Labor of the House Committee on Education and Labor, stated:

> Finally, I wish to make note of what is to many the crowning achievement of this legislation, the reservation to Federal authority [of] the sole power to regulate the field of employee benefit plans. With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation.

120 Cong. Rec. 29197 (1974). Similar remarks were made during the Senate floor debate on ERISA. 120 Cong. Rec. 29933 (1974).

Shaw expressly confirms that Congress sought to encourage uniformity in the ERISA plans of multistate employers. In this Court's words, "[b]y establishing benefit plan regulation 'as exclusively a federal concern,' * * * Congress minimized the need for interstate employers to administer their plans differently in each State in which they have employees" (103 S. Ct. at 2904, quoting *Alessi* v. *Raybestos-Manhattan, Inc., supra*, 451 U.S. at 523). The Supreme Judicial Court noted this congressional intent but held that "[i]t is inconsistent * * * with the broad language of the insurance exception" (App. A, 6a). Accordingly, the Massachusetts court refused to find preemption even though it acknowledged that its decision would adversely affect the ability of multistate employers to maintain uniform ERISA plans.

If state statutes like Section 47B can compel the inclusion of particular benefits in insurance policies sold to ERISA plans, nationwide plans seeking uniformity will have only two alternatives: either give up insurance altogether or adopt a single national policy that, at vastly increased expense, provides for all employees the most generous of each of the mandated benefits required by one or more states (assuming, of course, that no such minimum requirements conflict with each other). One law review article has described this dilemma very well:

> If states are permitted to require employee benefit plans to provide substantive benefits under the guise of insurance regulation, the result may be a Hobson's choice for employer or labor and management negotiators: either abandon the funding of benefit plans through insurance policies or be willing to accept all-encompassing uniform national contracts. For if each state may impose its own substantive terms on the plan, the only way uniformity may be reached is by incorporating into the plan all of the benefits each state requires. This dilemma is clearly of the type that Congress sought to avoid by enacting ERISA's preemption provisions, which were formulated to relieve interstate employee benefit plans of the adverse effects of cumulative or inconsistent state regulation.

Hutchinson and Ifshin, *Federal Preemption of State Law Under the Employment Retirement Income Security Act of 1974*, 46 U. Chi. L. Rev. 23, 68-69 (1978).[9]

Shaw reached an identical conclusion in the context of the state fair employment laws that were directly at issue there. The extended discussion in note 25 of this Court's opinion closely parallels the academic comments reproduced above (*see* 103 S. Ct. at 2904 n.25). *Shaw* thus provides strong support for appellant's position in the

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[9] The Hutchinson and Ifshin article was cited with approval in this Court's opinion in *Shaw*. 103 S. Ct. at 2901 n.19.

present case. The Congress that tried to encourage uniformity could hardly have intended that the only means of accomplishing that end would be either self-insurance or comprehensive compliance with all the various and shifting positions of state legislatures that choose to enact mandated benefit laws.

If a multistate plan does not adopt one of the foregoing alternatives, Section 47B and other mandated benefit statutes will produce disparate treatment of employees covered by the same health plan, depending on the state in which they reside.[10] For example, an employer's insured health plan, covering employees at a single plant, some living in Massachusetts and some living in Rhode Island, would be required to provide minimum coverage for the treatment of the mental and nervous conditions of the Massachusetts residents, but no such coverage

[10] Like Section 47B, some mandated benefit statutes expressly provide that they govern all health insurance policies covering residents of a particular state, regardless of the state in which the policies are issued or delivered. See Md. Ann. Code art. 48A, §§ 477E, 477X (Michie Supp. 1983); N.H. Rev. Stat. Ann. § 415:18-a (1983 & Supp. 1983); R.I. Gen. Laws § 27-38-1 to -8 (Michie Supp. 1983).

Other statutes do not specify whether they are intended to reach policies issued and delivered outside the state. Statutes in this group, however, may be construed by state insurance departments to include all policies that cover state residents. See, *e.g.*, N.D. Ins. Dep't Bull. #21 (Sept. 2, 1975) (construing N.D. Cent. Code §§ 26-39-03 to -04 (1978)).

Wisconsin has enacted a hybrid statute that provides that any policy having a specified minimum connection with the state must comply with all the requirements of the Wisconsin Insurance Code, including its various mandated benefit statutes. Wis. Stat. Ann. § 600.01 (West 1980 & Supp. 1983-1984). The statute applies to any health insurance policy under which at least 25% of the persons insured are Wisconsin residents employed in Wisconsin.

As these different statutory schemes show, the decision of the court below would require multistate employers and their insurance carriers to adhere to a large number of state laws that vary widely in their substantive provisions.

would be required for the Rhode Island residents. For this reason, and contrary to ERISA's intent, mandated benefit statutes entail substantial administrative costs and produce unequal benefits for similarly situated employees of the same employer. These problems are particularly acute for employers with many employees whose jobs require them to move frequently from one state to another.

2. *By providing an incentive for self-insurance, the decision below threatens to diminish the financial security of employee benefit plans*

ERISA itself draws no distinction between insured and noninsured plans. On the contrary, Section 3(1) of the Act, 29 U.S.C. 1002(1), explicitly includes within the definition of "employee welfare benefit plan" plans that provide benefits "through the purchase of insurance or otherwise." Under the rationale followed in the court below, however, states may mandate the benefits provided by insured plans but may not mandate the benefits provided by noninsured plans. This is precisely what Massachusetts has done and what the Supreme Judicial Court has approved.

By imposing additional burdens on insured plans only, mandated benefit statutes provide an incentive for plans to forgo the purchase of insurance policies and to establish their own funds for the payment of employee claims. The more onerous the benefits mandated by state laws, the greater the incentive for employee health plans to forgo insurance. This will skew the financial support of employee benefit plans in a way never intended by Congress, and it will increase the possibility that individual plans will not have sufficient funds available to fulfill their obligations to sick or injured employees.[11]

[11] In fact, as mandated benefit statutes have proliferated, the number of self-insured employee benefit plans has grown dramatically. It is, at the least, a reasonable inference that mandated

Moreover, the incentive toward self-insurance tends irrationally to favor large employee plans over small. Large plans are the ones more likely to have the funds necessary to take advantage of the self-insurance option, while smaller plans will be forced to purchase insurance and thus to provide mandated benefits.

Nothing whatsoever in the language or legislative history of ERISA suggests that Congress intended to make the states' power to regulate the substantive content of employee benefit plans turn on the size of the plan, or the plan's willingness or capacity to be a self-insurer. These factors bear no rational relationship to the legislative concerns underlying ERISA. The distinction produced by the Commonwealth's application of Section 47B and endorsed by the decision below therefore is inappropriate.

3. *Mandated benefit statutes inevitably will force plan participants to pay higher premiums or to surrender other desirable benefits*

When a state compels an insured employee benefit plan to provide certain benefits, the state does not offer to pay any of the cost of those benefits. Rather, the expense must be borne by those whom the mandated benefit statute is purportedly designed to help. Plan participants can pay for such new benefits in one of two ways. They can agree to increased premiums, or they can sacrifice one or more of the benefits already included in the plan

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benefit statutes have contributed to this trend. Uncontradicted testimony supporting this inference was given by three trial witnesses. A. 97, 179, 404.

The experience of appellant Metropolitan is instructive. In 1975, claims paid to beneficiaries of self-insured plans (for which Metropolitan provided only administrative services) amounted to approximately $20 million, or 1.2% of the total group health claims paid by Metropolitan during that year. By 1983, the annual dollar figure for self-insured plans administered by Metropolitan had grown to more than $740 million, and these claims represented 15.2% of all group health claims paid by the company.

in order to compensate for the mandated benefit. In either event, the state legislature will have improperly imposed its will on the plan and its members. In either event, employees' reasonable expectations regarding the costs and benefits associated with the plan will have been disappointed. (See, for example, the trial testimony of James M. Dawson, the administrator of several union health and welfare funds, describing the dissatisfaction of employees who were forced to sacrifice their existing coverage for eyeglasses and dental care to pay for the different benefits required by a state mandated benefit statute. A. 86-87.) ERISA's preemption provision was designed to eliminate precisely this kind of state regulation of employee benefit plans.

D. The Proper Reading of the Insurance Savings Clause

Three possible interpretations of the insurance savings clause have been proposed in this case.

First, the Commonwealth has argued that, because Section 47B purports to regulate insurance, it is automatically protected from preemption by the savings clause. This approach, which was followed by the First Circuit prior to the decision in *Alessi*,[12] was rejected by the Supreme Judicial Court in its earlier decision (App. D, 21a-22a) and was not even mentioned in the opinion on remand. It is a simplistic, mechanical approach that would permit the states to engage in virtually unlimited regulation of ERISA plans, as long as they couched their actions in terms of insurance regulation.

Second, the Supreme Judicial Court has held that a state law purporting to regulate insurance will not be preempted unless it conflicts with ERISA's substantive

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[12] See *Wadsworth* v. *Whaland*, 562 F.2d 70 (1st Cir. 1977), cert. denied, 435 U.S. 980 (1978). See also *Metropolitan Life Insurance Co.* v. *Whaland*, 119 N.H. 894, 410 A.2d 635 (1979); *Insurance Commissioner* v. *Metropolitan Life Insurance Co.*, 296 Md. 334, 463 A.2d 793 (1983).

provisions. Presumably, the court would find preemption where there is such a direct conflict. As we have shown, this approach is inconsistent with the breadth of ERISA's preemption provision, with the congressional intent to preclude state intrusions into the content of ERISA plans, and with the holdings and rationale of *Shaw* and *Alessi*.

Third, Metropolitan and Travelers have advocated an interpretation of the savings clause that gives full effect to the language of that clause, without surrendering to the states the broad regulatory power over employee benefit plans that was denied them by the preemption clause. In appellant's view, the preemption and savings clauses can be sensibly reconciled by confining the latter to the traditional areas of state insurance regulation, such as the specification of standards of conduct in sales and advertising, the prescription of criteria governing investment of funds, and the requirement that adequate reserves be maintained. *Michigan United Food & Commercial Workers Union & Food Employers Health & Welfare Fund* v. *Baerwaldt*, *supra*, 572 F. Supp. at 950-952. This approach, which focuses on the kinds of insurance regulation in which the states have traditionally engaged, permits state regulation in the areas that Congress almost certainly had in mind when it enacted the insurance savings clause. It does so without significantly affecting the operation of ERISA plans.

We can be quite confident that Congress was not thinking of mandated benefit statutes when it enacted ERISA. As far as we have been able to determine, no such statute existed before 1971, and only four states enacted such laws before 1973, when the insurance savings clause first appeared in the bills that led to ERISA.[13] No

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[13] See Ariz. Rev. Stat. Ann. § 20-1402(4)(b) (West Supp. 1983-1984) (enacted in 1971); Conn. Gen. Stat. Ann. § 38-174d (West Supp. 1984) (enacted in 1971); Ill. Ann. Stat. ch. 73, § 979(7) (Smith-Hurd Supp. 1983-1984) (enacted in 1972); 1971 Wis. Laws ch. 325.

Three additional states passed mandated benefit statutes after the savings clause appeared in bill form but before ERISA became law. See, in addition to Section 47B, Md. Ann. Code art. 48A, § 477E (Michie Supp. 1983); Minn. Stat. Ann. § 62A.149 (West Supp. 1984).

legislative evidence whatever suggests that ERISA sought to preserve mandated benefit statutes or that Congress even knew about such statutes when it enacted the savings clause. That clause therefore should not be construed to include statutes like Section 47B.

Congress did not wish to have historic protections for insureds undermined by a wooden application of the preemption clause. At the same time, however, Congress could not have wished to have the preemption clause undermined by a wooden application of the savings clause. At the least, the preemption clause was designed to prevent the states from interfering with the relationship between ERISA plan sponsors and plan participants. To construe the savings clause so as to permit state regulation of that relationship—to construe it to permit a state to mandate the benefits that the plan must provide—would be to drain the meaning from ERISA's preemption provision.

For all these reasons, this Court should intervene in this case to establish the correct relationship between ERISA and state mandated benefit laws, to reconcile the conflict in the lower courts, and to forestall future adverse effects of such state statutes on employee benefit plans.

CONCLUSION

Probable jurisdiction should be noted.

Respectfully submitted,

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August 1984

APPENDIX

APPENDIX

SUPREME COURT OF THE UNITED STATES

No. A-18

METROPOLITAN LIFE INSURANCE COMPANY AND
THE TRAVELERS INSURANCE COMPANY, APPELLANTS,

v.

MASSACHUSETTS

ORDER

UPON CONSIDERATION of the application of counsel for the appellants,

IT IS ORDERED that the time for docketing an appeal in the above-entitled case be, and the same is hereby, extended to and including September 22, 1984.

/s/ William J. Brennan, Jr.
Associate Justice of the
Supreme Court of the
United States

Dated this 12th
day of July, 1984.

Office - Supreme Court, U.S.
FILED
AUG 30 1984
ALEXANDER L. STEVAS,
CLERK

(2)

84 Nos. 325

In the Supreme Court of the United States

OCTOBER TERM, 1983

METROPOLITAN LIFE INSURANCE COMPANY, APPELLANT

v.

COMMONWEALTH OF MASSACHUSETTS

THE TRAVELERS INSURANCE COMPANY, APPELLANT

v.

COMMONWEALTH OF MASSACHUSETTS

ON APPEALS FROM THE SUPREME JUDICIAL COURT OF MASSACHUSETTS

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APPENDIX A

SUPREME JUDICIAL COURT OF MASSACHUSETTS
SUFFOLK

No. 2542

ATTORNEY GENERAL

v.

THE TRAVELERS INSURANCE COMPANY ET AL.[1]

Argued November 7, 1983

Decided April 25, 1984

Before HENNESSEY, C.J., and WILKINS, ABRAMS, NOLAN and O'CONNOR, JJ.

HENNESSEY, C.J. General Laws c. 175, § 47B, specifies mandatory minimum mental health care coverage under certain insurance policies.[2] The defendants declined to include such coverage in policies issued to welfare benefit plans subject to the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001 et seq. (1976 & Supp. V 1981). The Attorney General brought this action to compel the defendants to comply with

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[1] Metropolitan Life Insurance Co.

[2] General Laws c. 175, § 47B, inserted by St. 1973, c. 1174, § 2, provides in pertinent part: "Any blanket or general policy of insurance . . . or any policy of accident and sickness insurance . . . *or any employees' health and welfare fund* which provides hospital expense and surgical expense benefits . . . shall provide benefits for expense . . . arising from mental or nervous conditions . . ." (emphasis supplied).

We treat, as we did in the earlier opinion of this court (385 M— 598, 600), the language referring to employees' health and welfare funds (emphasized above) as preempted and severable.

§ 47B. The defendants argued that § 47B is preempted by ERISA. A judge of the Superior Court ordered the defendants to comply with § 47B, and we affirmed. 385 Mass. 598 (1982). The defendants appealed to the Supreme Court of the United States. That Court vacated our judgment and remanded for further consideration in light of its intervening decision in *Shaw* v. *Delta Air Lines, Inc.*, 103 S. Ct. 2890 (1983).

ERISA applies to all employee benefit plans except those specifically exempt under ERISA § 4(b), 29 U.S.C. § 1003(b) (1976). ERISA explicitly preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan," ERISA § 514(a), 29 U.S.C. § 1144(a) (1976), except that it does not "exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A) (1976).[3] In addition, ERISA may not "be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States." ERISA § 514(d), 29 U.S.C. § 1144(d) (1976).

In *Shaw*, the plaintiffs sought declarations that two New York State laws are preempted by ERISA in so far as they apply to benefit plans subject to ERISA. One, the Human Rights Law, forbids discrimination in employment on the basis of sex and has been held to prohibit treating pregnancy differently from other nonoccupational disabilities. See *Shaw*, *supra* at 2895. The other, the Disability Benefits Law, requires employers to provide the same benefits for pregnancy as for other nonoccupational disabilities. See *id.* at 2896.

The Supreme Court had "no difficulty" concluding, on the basis of plain language and legislative history, that both laws "relate to" employee benefit plans within the

[3] Other exceptions to ERISA's general preemption clause are not relevant here.

meaning of ERISA § 514(a), the general preemption provision. *Id.* at 2899-2901. It rejected the suggestions that the preemption provision could be interpreted "to pre-empt only state laws dealing with the subject matters covered by ERISA—reporting, disclosure, fiduciary responsibility, and the like." *Id.* at 2900. In addition, the Court emphasized "Congress' goal of ensuring that employers would not face 'conflicting or inconsistent State and local regulation of employee benefit plans.'" *Id.* at 2904, quoting 120 Cong. Rec. 29,933 (1974) (remarks of Senator Williams). It noted the "inefficiency" that would result from requiring interstate employers to conform to differing State requirements. *Shaw*, *supra* at 2904 & n.25.

With respect to the Human Rights Law, the *Shaw* defendants argued that, because State fair employment laws play an integral role in the enforcement of Title VII of the Civil Rights Act of 1964, construing § 514(a) to preempt the Human Rights Law would impair Federal law and thus violate § 514(d). The Supreme Court, however, decided that the "minor practical difficulties" for Title VII enforcement "do not represent the kind of 'impairment' or 'modification' of *federal* law that can save a *state* law from preemption under § 514(d)" (emphasis in original). *Id.* at 2904.

With respect to the Disability Benefits Law, the *Shaw* defendants argued that because plans "maintained solely for the purpose of complying with applicable . . . disability insurance laws" are exempt from ERISA coverage under § 4(b)(3), the law could not be preempted by § 514(a). The Supreme Court decided that "§ 4(b)(3) excludes 'plans,' not portions of plans, from ERISA coverage; those portions of the [plaintiffs'] multi-benefit plans maintained to comply with the Disability Benefits Law, therefore, are not exempt from ERISA and are not subject to state regulation." *Id.* at 2905. The Court stated, however, that the State could enforce its law by

compelling the employer "to choose between providing disability benefits in a separately administered plan and including the state-mandated benefits in its ERISA plan." *Id.* at 2906.

We conclude that nothing in the *Shaw* opinion requires that we change the result we previously reached in this case. To hold that § 47B is preempted would frustrate a strong State policy of encouraging the prompt and thorough treatment of mental disorders. It may be argued, on the basis of intimations in *Shaw*, that the Supreme Court would reach a different result, but we decline to anticipate such a ruling. We think that nothing in the congressional language or in the language of the Supreme Court requires us to sacrifice our State policy.

The defendants make much of the Supreme Court's characterization of the exceptions to § 514(a) as "narrow." However, we view this characterization by the Court as dictum.[4] According to § 514(a), the only exceptions to preemption are those provided for in subsection (b),[5] yet, the Supreme Court did not construe that subsection in *Shaw*. One of the provisions it construed is a narrowly phrased *exemption* from ERISA coverage, not an *exception* to preemption. See ERISA § 4(b)(3). The other provision, although treated as an exception by the Supreme Court, is not phrased as an exception and would rarely, if ever, function as such. See ERISA § 514(d).

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[4] As the defendants pointed out in oral argument, the *Shaw* opinion "went out of its way" to stress the narrowness of the exception clauses.

[5] ERISA § 514 (a), 29 U.S.C. § 1144(a), provides in part: "Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title."

Unlike the provisions at issue in *Shaw*, the insurance exception to preemption is phrased very broadly: "*nothing* in this subchapter shall be construed to exempt or relieve *any* person from *any* law of any State which regulates insurance . . ." (emphasis supplied). ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). We have interpreted this provision to save from preemption only those State laws that do not conflict with the policies or operation of ERISA. See 385 Mass. at 607-609. This interpretation is relatively narrow; we rejected the broad interpretation which was accepted in *Wadsworth* v. *Whaland*, 562 F.2d 70, 77-78 (1st Cir. 1977), cert. denied, 435 U.S. 980 (1978), and *Metropolitan Life Ins. Co.* v. *Whaland*, 119 N.H. 894, 902 (1979). That the Supreme Court has rejected a conflict-based analysis as producing too narrow an interpretation of the broadly phrased preemption provision does not imply that it would reject a conflict-based analysis as producing too broad an interpretation of the broadly phrased insurance exception. We adhere to our prior interpretation of the exception.[6]

The *Shaw* opinion does provide support for the defendants' argument that Congress intended to curtail State police power in order to enable interstate employers to

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[6] Our conflict-based interpretation of the exception can be supported under an alternative analysis. We could conclude, as in the *Whaland* cases, that because § 47B regulates insurance it is automatically within the exception and thus removed from the operation of the preemption clause. That conclusion need not end the analysis. Laws that interfere with a congressional scheme of comprehensive regulation are preempted without any need for a preemption clause. See, e.g., *Burbank* v. *Lockheed Air Terminal, Inc.*, 411 U.S. 624 (1973). A law which purported to regulate insurance but interfered with the congressional scheme of regulation the administration of employee benefit plans could be within the exception yet nonetheless preempted. As we noted before, "Section 47B affects only the substantive content of plans—a subject completely untouched by ERISA's regulatory provisions." 385 Mass. at 607.

maintain uniform plans. The Supreme Court concluded that this was indeed Congress's intent. See 103 S. Ct. at 2900-2901, 2903-2904. This conclusion is based on the key phrase in the legislative history: "conflicting and inconsistent State and local regulation." This phrase is as susceptible of our interpretation—i.e., conflicting and inconsistent with Federal law, see 385 Mass. at 607-608 & n.16—as of the Supreme Court's interpretation—i.e., conflicting and inconsistent among the States, see 103 S. Ct. at 2904 & n.25. Nonetheless, we must accept as authoritative the Supreme Court's interpretation of congressional intent.

Congress's intent to preclude the States from mandating employee benefits does not require that we change the result in this case. "[T]he court cannot read into a statute an intent that is not there expressed in plain words or by necessary implication." *Tilton* v. *Haverhill*, 311 Mass. 572, 578 (1942). See *Bate Refrigerating Co.* v. *Sulzberger*, 157 U.S. 1, 36-37 (1895) (Harlan, J.); *Commonwealth* v. *Gove*, 366 Mass. 351, 354-355 (1974). The intent ascribed to Congress by the Supreme Court is consistent with the broad language of the preemption provision. It is inconsistent, however, with the broad language of the insurance exception. The *Shaw* case did not require the Supreme Court to strain the language of the statute in order to give effect to the legislative intent. But to conclude that a State cannot mandate employee benefits indirectly through its insurance laws would require an unnaturally narrow reading of the phrase "any law . . . which regulates insurance." Mandated coverage is within the States' traditional authority to regulate insurance. "[U]nless Congress conveys its purpose clearly, it will not be deemed to have significantly changed the federal-state balance." *United States* v. *Bass*, 404 U.S. 336, 349 (1971). See *Wadsworth* v. *Whaland*, *supra* at 78.

Because we treat the reference in § 47B to "any employees' health and welfare fund" as preempted, and the remaining language of the statute as severable (see note 2, *supra*), the statute as we consider it makes no attempt to regulate employee benefit plans directly. Nor is it an attempt to do indirectly what cannot be done directly. The statute applies to health and accident insurance policies, whether issued to employee benefit plans or not. Unquestionably, a large proportion of such policies is unrelated to such plans. Thus the statute is not an attempt to intrude upon the sphere reserved to ERISA, but rather a bona fide regulation of insurance. It is within the spirit, as well as the letter, of the insurance exception to ERISA preemption.

We conclude that the decision in *Shaw* v. *Delta Air Lines, Inc.*, 103 S. Ct. 2890 (1983), does not require us to change our prior decision that § 47B is not preempted by ERISA.

Judgment affirmed.

WILKINS, J. (dissenting). I disagree with the court's conclusion that ERISA does not preempt the mandate of G. L. c. 175, § 47B, as to minimum mental health care coverage under certain insurance policies. The Supreme Court's unanimous opinion in *Shaw* v. *Delta Air Lines, Inc.*, 103 S. Ct. 2890 (1983), indicates forcefully that the Court would not grant wide scope to the insurance exception expressed in ERISA § 514(b)(2)(A). *Id.* at 2903. The *Shaw* opinion tells us that exemptions, and, I think, exceptions from preemption are to be read narrowly because a contrary view would destroy the option of a multistate employer to have a uniform ERISA plan and because any special State requirement for a disability plan could be provided as a separate administrative unit. *Id.* at 2904-2906.

General Laws c. 175, § 47B, is not a law "which regulates insurance" within the meaning of ERISA § 514(b)(2)(A). As applied to employers, § 47B concerns health benefits that an employer must provide, by insurance or otherwise, if the employer provides any such benefits at all, and as to employee benefits § 47B only incidentally regulates insurance. Section 47B represents precisely that form of local intrusion on ERISA covered benefit plans that ERISA intends to prevent. See *Delta Air Lines, Inc.* v. *Kramarsky*, 725 F.2d 146, 148 (2d Cir. 1983). Congress has adopted an all-inclusive preemption scheme, and it is now clear, in light of the *Shaw* opinion, that it is irrelevant whether State law dictating plan benefits conflicts with the substantive policies of ERISA.

APPENDIX B

COMMONWEALTH OF MASSACHUSETTS

SUPREME JUDICIAL COURT FOR THE COMMONWEALTH
AT BOSTON

April 25, 1984

IN THE CASE NO. SJC-2542

ATTORNEY GENERAL

vs.

THE TRAVELERS INSURANCE COMPANY

& another pending in the Superior Court Department of the Trial Court for the County of Suffolk No. 35598

ORDERED, that the following entry be made in the docket; viz., —

Judgment affirmed.

BY THE COURT,

/s/ Patrick M. Hurley,
Clerk

April 25, 1984.
See opinion on file.

APPENDIX C

SUPREME COURT OF THE UNITED STATES

Nos. 82-299 and 82-300

METROPOLITAN LIFE INSURANCE COMPANY,
Appellant,

v.

MASSACHUSETTS; and

TRAVELERS INSURANCE COMPANY,
Appellant,

v.

MASSACHUSETTS

Appeals from the Supreme Judicial Court of Massachusetts

THESE CAUSES having been submitted on the statements as to jurisdiction and motions to affirm,

ON CONSIDERATION WHEREOF, it is ordered and adjudged by this Court that the judgment of the above court in these causes is vacated with costs, and that these causes are remanded to the Supreme Judicial Court of Massachusetts for further consideration in light of *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. —— (1983).

IT IS FURTHER ORDERED that the appellants, Metropolitan Life Insurance Company and Travelers Insurance Company, recover from Massachusetts Four Hundred Dollars ($400.00) for their costs herein expended.

July 6, 1983

Clerk's costs: $400.00

UNITED STATES OF AMERICA, ss:

THE PRESIDENT OF THE UNITED STATES OF AMERICA

To the Honorable the Justices
of the Supreme Judicial Court
of Massachusetts,

GREETINGS:

WHEREAS, lately in the Supreme Judicial Court of Massachusetts, there came before you a cause between Attorney General and The Travelers Insurance Company, et al., No. 2542, wherein the judgment of the said Supreme Court was duly entered on the twenty-fourth day of March, 1982, as appears by an inspection of the statements as to jurisdiction and motions to affirm.

AND WHEREAS, in the 1982 Term, the said causes having been submitted to the SUPREME COURT OF THE UNITED STATES on the said statements as to jurisdiction and motions to affirm,

ON CONSIDERATION WHEREOF, it was ordered and adjudged on July 6, 1983, by this Court that the judgment of the said Supreme Court in these causes is vacated with costs, and that these causes are remanded to the Supreme Judicial Court of Massachusetts for further consideration in light of *Shaw* v. *Delta Air Lines*, 463 U.S. —— (1983).

IT IS FURTHER ORDERED that the appellants, Metropolitan Life Insurance Company and Travelers Insurance Company, recover from Massachusetts Four Hundred Dollars $400.00) for their costs herein expended.

NOW, THEREFORE, THE CAUSE IS REMANDED to you in order that such proceedings may be had in the said cause, in conformity with the judgment of this Court above stated, as accord with right and justice, and the Constitution and Laws of the United States.

Witness the Honorable WARREN E. BURGER, Chief Justice of the United States, the 8th day of August in the year of our Lord one thousand nine hundred and eighty-three.

Costs of Metropolitan Life Insurance Company and Travelers Insurance Company

Clerk's costs: $400.

/s/ Alexander L. Stevas
Clerk of the Supreme Court
of the United States

No. 82-299

Metropolitan Life Insurance Company

v.

Massachusetts

82-300

Travelers Insurance Company

v.

Massachusetts

APPENDIX D

SUPREME JUDICIAL COURT OF MASSACHUSETTS
SUFFOLK

No. 2542

ATTORNEY GENERAL

v.

THE TRAVELERS INSURANCE COMPANY ET AL.[1]

Argued Dec. 9, 1981

Decided March 24, 1982

Before HENNESSEY, C. J., and WILKINS, LIACOS, NOLAN and O'CONNOR, JJ.

HENNESSEY, Chief Justice.

General Laws c. 175, § 47B, specifies mandatory minimum mental health care benefits for Massachusetts residents, which must be included in any general insurance policy, accident or sickness insurance policy, or employee health care plan, if the policy or plan covers hospital and surgical expenses.[2] The principal question before us is

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[1] Metropolitan Life Insurance Co.

[2] General Laws c. 175, § 47B, inserted by St. 1973, c. 1174, § 2, provides that: "Any blanket or general policy of insurance described in subdivision (A), (C), or (D) of section one hundred and ten which provides hospital expense and surgical expense insurance and which is issued or subsequently renewed by agreement between the insurer and the policyholder, within or without the commonwealth, during the period this provision is effective, or any policy of accident and sickness insurance as described in section one hundred and eight which provides hospital expense and surgical expense insurance and which is delivered or issued for delivery or subsequently renewed by agreement between the insurer and the policyholder in this commonwealth during the period that this provision is effective, or any employees' health and welfare fund which provides hospital expense and surgical expense benefits

whether § 47B is preempted by either the Employee Retirement Income Security Act, 29 U.S.C. § 1001 et seq. (1976, Supp. I 1977, & Supp. II 1978) (ERISA), or the National Labor Relations Act, 29 U.S.C. § 151 et seq. (1976 & Supp. III 1979) (NLRA). In addition, the defendant insurance companies raise issues concerning severability, the effect of § 47B on policies issued before its effective date in 1976, and the applicability of the contract clause of the United States Constitution, art. 1, § 10. We conclude that the provisions of § 47B pertaining to insurance are not preempted, and that they are severable from a provision pertaining to employee benefit plans,

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and which is promulgated or removed to any person or group of persons in this commonwealth while this provision is effective shall provide benefits for expense of residents of the commonwealth covered under any such policy or plan, arising from mental or nervous conditions as described in the standard nomenclature of the American Psychiatric Association which are at least equal to the following minimum requirements:

"(a) In the case of benefits based upon confinement as an inpatient in a mental hospital under the direction and supervision of the department of mental health, or in a private mental hospital licensed by the department of mental health, the period of confinement for which benefits shall be payable shall be at least sixty days in any calendar year.

"(b) In the case of benefits based upon confinement as an inpatient in a licensed or accredited general hospital, such benefits shall be no different than for any other illness.

"(c) In the case of outpatient benefits, these shall cover, to the extent of five hundred dollars over a twelve-month period, services furnished (1) by a comprehensive health service organization, (2) by a licensed or accredited hospital (3) or subject to the approval of the department of mental health services furnished by a community mental health center or other mental health clinic or (4) consultations or diagnostic or treatment sessions, provided that such services under this clause are rendered by a psychotherapist or by a psychologist licensed under the provisions of chapter one hundred and twelve. For purposes of this clause 'psychotherapist' shall mean a person fully licensed to practice medicine under the provisions of chapter one hundred and twelve, who devotes a substantial portion of his time to the practice of psychiatry."

which the parties have assumed to be preempted. We also conclude that § 47B applies to certain policies issued by the defendants before 1976, and that this application of the statute does not violate the contract clause.

The Attorney General brought this action for declaratory and injunctive relief to enforce § 47B against insurance companies that issue group insurance policies providing medical coverage to Massachusetts employees.[3] The parties stipulated that nearly all of the defendants' group policies covering Massachusetts employees insure welfare benefit plans subject to ERISA. In addition, a number of the policies insure plans mandated by collective bargaining agreements negotiated pursuant to the NLRA.

A Superior Court judge issued a preliminary order requiring the defendants to provide the mental health coverage described in § 47B. After trial, a second judge granted a permanent order to the same effect. We granted the defendants' application for direct appellate review.

1. *Severability.*

Although § 47B applies by its terms to "employees' health and welfare fund[s]," as well as to policies of insurance, the Attorney General has not enforced it against uninsured plans subject to ERISA. The present case involves only insurers, and all parties have assumed that direct enforcement against plans is preempted by ERISA. A threshold question, therefore, is whether the provisions

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[3] The defendants have not included the required benefits in certain policies issued outside Massachusetts that provide coverage for Massachusetts employees, and certain policies issued before January 1, 1976. (These will be discussed later in this opinion.) The parties stipulated that the defendants have included the required benefits in policies issued or renewed in Massachusetts after January 1, 1976, but the defendants reserved the right to challenge § 47B as applied to these policies. Thus the defendants are asserting the invalidity of the statute with respect to all policies of insurance, whether issued before or after January 1, 1976, inside or outside the Commonwealth.

of § 47B requiring the inclusion of mental health care benefits in policies of insurance are severable from the provision pertaining directly to benefit plans. We believe that they are. The insurance requirements "have independent force, thus justifying the inference that the enacting body would have passed one without the other." *DelDuca v. Town Adm'r of Methuen*, 368 Mass. 1, 13, 329 N.E.2d 748 (1975). The judge's findings indicate that many plans purchase insurance, and that § 47B as currently enforced (against insurers only) has brought about significant improvements in mental health care in Massachusetts. The judge also found that there was no credible evidence that partial enforcement of § 47B had caused plans to shift to self-insurance.

In light of our conclusion that the insurance provisions of § 47B are independently enforceable, the following discussion of preemption will be limited to the statute's application to policies of insurance.

2. *Preemption—General Principles.*

By the operation of the supremacy clause of the United States Constitution, art. 6, Federal law preempts conflicting State law. *Gibbons v. Ogden*, 22 U.S. (9 Wheat.) 1, 210-211, 6 L.Ed.23 (1824). The conflict may be direct, in the sense that State regulation contradicts Federal regulation, see *McDermott v. State*, 228 U.S. 115, 132-134, 33 S.Ct. 431, 435-436, 57 L.Ed. 754 (1913), or interferes with Federal policy, see *Burbank v. Lockheed Air Terminal, Inc.*, 411 U.S. 624, 639, 93 S.Ct. 1854, 1862, 36 L.Ed. 2d 547 (1973), or it may arise from congressional intent, express or implied, to exclude all State regulation from a particular area. See *Commonwealth v. Federico*, —— Mass. ——, ——, Mass.Adv.Sh. (1981) 1052, 1056, 419 N.E.2d 1374; *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 522-525, 101 S.Ct. 1895, 1905-1907, 68 L.Ed.2d 403 (1981); *Chicago & N.W. Transp. Co. v. Kalo Brick & Tile Co.*, 450 U.S. 311, 324-326, 101 S.Ct. 1124, 1133-1134, 67 L.E.2d 258 (981). See generally L. Tribe, Ameri-

can Constitutional Law 376-389 (1978). Preemption, however, is not favored, and State laws should be upheld unless a conflict with Federal law is clear. A finding of preemption must rest upon "persuasive reasons—either that the nature of the regulated subject matter permits no other conclusion, or that the Congress has unmistakably so ordained." *Alessi v. Raybestos-Manhattan, Inc.*, *supra*, 451 U.S. at 522, 101 S.Ct. at 1905, quoting from *Florida Lime & Avocado Growers v. Paul*, 373 U.S. 132, 142, 83 S.Ct. 1210, 1217, 10 L.Ed.2d 248, amended in other respects, 373 U.S. 929, 83 S.Ct. 1210, 10 L.Ed.2d 248 (1963).

3. *Does ERISA preempt § 47B?*

Congress enacted ERISA in 1974 to protect the interests of beneficiaries of employee benefit plans. 29 U.S.C. § 1001 (1976). *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 510, 101 S.Ct. 1895, 1899, 68 L.Ed.2d 403 (1981). *Nachman Corp. v. Pension Benefit Guaranty Corp.*, 446 U.S. 359, 374-375, 100 S.Ct. 1723, 1732-1733, 64 L.Ed.2d 354 (1980). Prior Federal law[4] had preserved primary responsibility for regulation of benefit plans to the States. See *Malone v. White Motor Corp.*, 435 U.S. 497, 505-512, 98 S.Ct. 1185, 1190-1193, 55 L.Ed. 2d 443 (1978). See generally Hutchinson & Ifshin, Federal Preemption of State Law under the Employee Retirement Income Security Act of 1974, 46 U.Chi.L.Rev. 23, 25-30 (1978). In its place, ERISA outlined a detailed system for Federal regulation of benefit plan administration. *Alessi v. Raybestos-Manhattan, Inc.*, *supra*, 451 U.S. at 510, 101 S.Ct. at 1899.

ERISA applies to two types of benefit plan—"pension plans," which provide retirement benefits or deferred income;[5] and "welfare plans, which provide nonpension

[4] The Welfare and Pension Plans Disclosure Act of 1958, Pub.L. No. 85-836, 72 Stat. 997 (1958) (repealed 1974, 29 U.S.C. § 1031[a][1] [1976]).

[5] 29 U.S.C. § 1002(2) (1976).

benefits including medical and hospital expenses.[6] *Wadsworth v. Whaland*, 562 F.2d 70, 74 (1st Cir. 1977), cert. denied, 435 U.S. 980, 98 S.Ct. 1630, 56 L.Ed.2d 72 (1978). ERISA's regulatory provisions establish disclosure requirements and fiduciary standards applicable to both pension and welfare plans,[7] as well as funding and vesting requirements applicable only to pension plans.[8] Other sections of the act provide for enforcement and administration, and for national insurance against termination of pension plans. See generally, Hutchinson & Ishfin, *supra* at 30-34.

ERISA also contains express provisions defining its preemptive effect on State law. Three provisions are relevant here. First, the act's general preemption clause states in sweeping terms that ERISA supersedes all State laws that "relate to" employee benefit plans.[9] This general clause, however, is followed by a savings clause that exempts any State law that "regulates insurance" from the preemptive effect of the act.[10] The savings clause is

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[6] 29 U.S.C. § 1002(1) (1976).

[7] 29 U.S.C. §§ 1021-1031 (reporting and disclosure); §§ 1101-1114 (fiduciary responsibility) (1976).

[8] 29 U.S.C. §§ 1051-1061 (participation and vesting) §§ 1081-1086 (funding) (1976).

[9] 29 U.S.C. §§ 1144(a) (1976) provides in relevant part that: "Except as provided in subsection (b) of this section, the provisions of . . . [ERISA] shall supersede any and all laws insofar as they may now or hereafter relate to any employee benefit plan." The term "employee benefit plan" refers to both pension plans and welfare plans. 29 U.S.C. § 1002(3) (1976).

[10] "Except as provided in subparagraph (B) [the "deemer" limitation discussed *infra*], nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities." 29 U.S.C. § 1144 (b)(2)(A). This exemption is in accord with the McCarran-Ferguson Act, 15 U.S.C. § 1011-1015 (1976), which establishes a Federal policy in favor of State regulation of insurance. See *SEC v. National Sec., Inc.*, 393 U.S. 453, 458-460, 89 S.Ct. 564, 567-568,

limited in turn by a third clause which provides that a State may not "deem" that a benefit plan is an insurer subject to its insurance laws.[11]

The Attorney General argues that § 47B is a law that "regulates insurance," and is therefore exempted from preemption by ERISA's savings clause. The defendants argue that because the purpose and effect of § 47B are to regulate benefits, it should not be saved from preemption as an insurance law.

Persuasive authority supports the Attorney General's position. Both the United States Court of Appeals for the First Circuit and the Supreme Court of New Hampshire have rejected preemption challenges to a New Hampshire law nearly identical to § 47B.[12] *Wadsworth v. Whaland*, 562 F.2d 70 (1st Cir. 1977); *Metropolitan Life Ins. Co. v. Whaland*, 119 N.H. 894, 410 A.2d 635 (1979). The defendants suggest that these decisions are not soundly reasoned, and have been undermined by a recent decision of the United States Supreme Court, *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 101 S.Ct. 1895, 68 L.Ed. 2d 403 (1981). We disagree. In light of the *Alessi* deci-

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21 L.Ed.2d 668 (1969); *Wadsworth v. Whaland*, 562 F.2d 70, 78 (1st Cir. 1977), cert. denied, 435 U.S. 980, 98 S.Ct. 1630, 56 L.Ed.2d 72 (1978).

[11] "Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies." 29 U.S.C. § 1144(b)(2)(B) (1976).

[12] Like § 47B, the New Hampshire statute, N.H.Rev.Stat.Ann. § 415:18a (Supp. 1979), requires insurers to include minimum mental health care benefits in all group policies covering hospital or medical expenses. The New Hampshire law does not apply directly to employee benefit plans, as does § 47B. As we have noted, however, the provision in § 47B for direct regulation of benefit plans is not before us.

sion, however, we will set forth our reasoning in some detail.

We first address the language of ERISA's preemption and savings provisions, to determine whether Congress has "unmistakably . . . ordained" preemption of § 47B. *Id.* at 522, 101 S.Ct. at 1905, quoting *Florida Lime & Avocado Growers v. Paul*, 373 U.S. 132, 142, 83 S.Ct. 1210, 1217, 10 L.Ed.2d 248, amended in other respects, 373 U.S. 929, 83 S.Ct. 1210, 10 L.Ed.2d 248 (1963). In *Alessi*, the Supreme Court adopted a broad construction of ERISA's general preemption clause, holding that the clause applied to a New Jersey workers' compensation law that prohibited set-offs of workmen's compensation payments against pension benefits. The Court reasoned that the New Jersey statute was a law "relat[ing] to" pension plans because it foreclosed a method of calculating pension benefits. 451 U.S. at 524-525, 101 S.Ct. at 1906-1907. The Court added that "[i]t is of no moment that New Jersey intrudes indirectly, through a workers' compensation law rather than directly, through a statute called 'pension regulation.'" *Id.* at 525, 101 S.Ct. at 1907. See also 29 U.S.C. § 1144(c)(2) (1976).

The Court's analysis in *Alessi* suggests that § 47B is a law that "relate[s] to" benefit plans, within ERISA's general preemption clause. Because a plan that purchases insurance has no choice but to provide mental health care benefits, the insurance provisions of § 47B effectively control the content of insured welfare benefit plans. Although grounds of distinction may exist between *Alessi* and the present case,[13] the Attorney General has not pressed them, and we treat § 47B as a law that "relate[s]

[13] *Alessi*, which involved State regulation of matters within the scope of ERISA's regulatory provisions (see *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 514-521, 101 S.Ct. 1895, 1901-1905, 68 L.Ed.2d 403 [1981]), does not necessarily undermine the reasoning expressed in *Gast v. State*, 36 Or.App. 441, 452-459, 585 P.2d 12 (1978). See *Alessi*, *supra* 451 U.S. at 525 n.21, 101 S.Ct. at 1907.

to" employee benefit plans. See *Commonwealth v. Federico*, —— Mass. ——, ————, Mass.Adv.Sh. (1981) 1052, 1055-1056, 419 N.E.2d 1374.

This brings us to the savings clause, which exempts "any law of any state which regulates insurance." 29 U.S.C. § 1144(b)(2)(A) (1976). The defendants insist that § 47B is not an insurance law, because it is designed to promote public health,[14] rather than to regulate "traditional" subjects of State insurance. The language of the savings clause, however, is not limited to "traditional" insurance laws, even if such a category could be defined. Contrast *Commonwealth v. Federico*, —— Mass. ——, Mass.Adv.Sh. (1981) 1052, 419 N.E.2d 1374 (savings clause for "generally applicable" criminal laws). The only express limit on the savings clause is the third clause, sometimes called the "deemer" clause, which prevents States from deeming plans to be insurers. See *Wadsworth v. Whaland*, 562 F.2d 70, 77-79 (1st Cir. 1977); *Metropolitan Life Ins. Co. v. Whaland*, 119 N.H. 894, 902, 410 A.2d 635 (1979). On the other hand, we cannot agree with the Attorney General's contention that our analysis should end with the deemer clause. In the Attorney General's view, if § 47B applies to insurance, and does not treat plans as insurers, it is not preempted. See *Wadsworth v. Whaland*, *supra* at 77-78; *Metropolitan Life Ins. Co. v. Whaland*, *supra* 119 N.H. at 902, 410 A.2d 635. We are wary of such a literal reading, which might permit the State, through its insurance laws, to reach far into areas governed by ERISA, and thereby negate the unmistakable intent of Congress to work a broad preemption. The deemer clause is one indication of the intended breadth of the savings clause, but we do not accept it as determinative. We conclude only that the language of the

[14] The public health objectives of § 47B are described at length in the trial judge's findings, and are documented in a post-enactment report of the Joint Committee on Insurance. General Court, Joint Committee on Insurance, Advances in Health Insurance in Massachusetts (August, 1974). See note 24, *infra*.

savings clause is broad enough to permit a construction that would exempt § 47B from preemption. Beyond this, the term "insurance law," and the wording of the deemer clause are of little help.

We prefer to resolve the tension between the general preemption clause and the savings clause by reference to the policies and operation of ERISA, and the general principle that preemption should not be implied unless there is a clear conflict between State and Federal law. *Chicago & N.W. Transp. Co. v. Kalo Brick & Tile Co.*, 450 U.S. 311, 317-318, 101 S.Ct. 1124, 1130, 67 L.Ed.2d 258 (1981). *Jones v. Rath Packing Co.*, 430 U.S. 519, 525-526, 97 S.Ct. 1305, 1309-1310, 51 L.Ed.2d 604 (1977). Congress, when it enacted ERISA, was concerned with widespread abuses in plan administration, often resulting in employees' losses of anticipated benefits. 29 U.S.C. § 1001(a) (1976). *Wadsworth v. Whaland*, *supra* at 73-74. See *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 510, 101 S.Ct. 1895, 1899, 68 L.Ed.2d 403 (1981). In response, Congress enacted rules governing disclosure and fiduciary conduct by administrators of welfare benefit plans.[15] 29 U.S.C. §§ 1001(b), 1021-1031, 1101-1114 (1976). Section 47B has no bearing on the problem of administrative abuse, and does not overlap or interfere with the means chosen by Congress to deal with such abuse. Section 47B affects only the substantive content of plans—a subject completely untouched by ERISA's regulatory provisions. See *Gast v. State*, 36 Or.App. 441, 452-458, 585 P.2d 12 (1978). Therefore, nothing in the practical relationship between the two statutes calls for an implied limitation on the phrase "regulates insurance" that would exclude § 47B from the protection of the savings clause.

The defendants discern an additional "policy" in ERISA's preemption provisions. They suggest that Con-

[15] In the area of pension plans, Congress also established vesting and funding requirements. 29 U.S.C. §§ 1001(c), 1051-1086 (1976).

gress intended to designate an area of private self-determination with respect to choice of benefits, and to protect it from all State regulation. But the defendants have not identified persuasive evidence in the legislative history of an affirmative policy to curtail State police power in favor of private decision-making. See *Gast v. State*, *supra*, 36 Or.App. at 457-458, 585 P.2d 12. To the contrary, comments during floor debates indicate that broad preemption language was favored in order to provide a clear line of demarcation and to deter States from enacting inconsistent laws on the periphery of ERISA's subject matter.[16] Nor does the Supreme Court's opinion in *Alessi*, *supra*, support the defendants' view that Congress intended to establish strict protection of self-determination in an area outside the scope of ERISA's regulatory provisions. In fact, the Court emphasized in its discussion of preemption that the New Jersey law at issue affected a subject covered by ERISA.[17]

[16] For example, Congressman John Dent, Chairman of the Subcommittee on Labor of the House Labor and Education Committee, commented that "[w]ith the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation." 120 Cong. Rec. 29197 (1974). Senator Jacob Javits, a member of the Senate Committee on Labor and Public Welfare, described the history of the broad general preemption clause in similar fashion: "Both House and Senate bills provided for preemption of State law, but . . . defined the perimeters of preemption in relation to the areas regulated by the bill. Such a formulation raised the possibility of endless litigation over the validity of State action that might impinge on Federal regulation, as well as opening the door to multiple and potentially conflicting State laws hastily contrived to deal with some particular aspect of private welfare or pension benefit plans not clearly connected to the Federal regulatory scheme." 120 Cong. Rec. 29942 (1974). Such statements simply do not reveal a calculated, affirmative design to extend the preemptive effect of ERISA far beyond the reach of the act's regulatory provisions, in order to create an area reserved to unhindered private ordering.

[17] The Court noted that ERISA permitted set-off techniques. *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 510, 524, 101 S.Ct. 1895, 1899, 1906-1907, 68 L.Ed.2d 403 (1981). In an earlier

The defendants also contend that ERISA established a policy in favor of uniformity with respect to benefit plans, which would be undermined if States were permitted to impose varying requirements on the substantive content of plans. The defendants point out that businesses that employ workers in a number of different States would be unable to adopt standardized plans covering all of their employees. We are not persuaded by this argument. Congress undoubtedly contemplated a system of uniform, national regulation in the areas governed by ERISA. On the other hand, it specifically approved State regulation in the fields of insurance, banking, and securities, and so could not have intended to mandate complete uniformity for the convenience of multi-state employers. Moreover, the judge below stated in his findings that the defendants had presented "no credible evidence that [diverse State mandatory benefit laws] would be any more complex or burdensome to interstate commerce than various other . . . multi-state regulatory schemes such as workmen's compensation laws."

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section of the opinion, devoted to interpretation of ERISA, the Court also suggested that Congress, by its acquiescence in a prior regulation of the Internal Revenue Service, had authorized the precise set-off technique prohibited by the New Jersey law. *Id.* at 517-521, 101 S.Ct. at 1903-1905.

The defendants cite a statement in the Court's discussion of preemption by the NLRA, that "ERISA leaves . . . pension calculation techniques . . . to the discretion of pension plan designers." *Id.* at 525, 101 S.Ct. at 1907. They also quote out of context statements made in the first section of the opinion, which dealt with interpretation of ERISA. There, the Court asked "what defines the content of the benefit that, once vested, cannot be forfeited," and answered that "ERISA leaves this question largely to the private parties . . . . That the private parties, not the government, control the level of benefits is clear from the statutory language defining nonforfeitable rights." *Id.* at 511, 101 S.Ct. at 1900. At most, these statements suggest that private parties control the designation of particular benefits as nonforfeitable—a small area of self-determination well within the scope of ERISA's regulatory provisions (29 U.S.C. §§ 1051-1061 [1976], governing vesting of pension benefits).

In sum, there is no conflict between § 47B and the policies or operation of ERISA that calls for a narrow interpretation of the phrase "regulates insurance" in the savings clause of ERISA's preemption provisions. Therefore, we conclude that ERISA does not preempt § 47B.

4. *Does the NLRA Preempt § 47B?*

Congress enacted the NLRA in 1935 to combat industrial strife by encouraging collective bargaining on terms and conditions of employment. 29 U.S.C. § 151 (1976). The act protects employees' rights to organize and to engage in concerted activity, and defines unfair labor practices by employers and unions. See 29 U.S.C. §§ 157-160 (1976). Certain of the insurance policies issued by the defendants insure plans agreed to through collective bargaining,[18] and the defendants contend that the NLRA preempts application of § 47B to these policies.

The issue of preemption takes a different form under the NLRA than under ERISA. The NLRA does not provide expressly for preemption of State law, as does ERISA. Thus, the NLRA's preemptive effect must be discerned entirely by implication from the policies of the act. On the other hand, Congress clearly did intend, in enacting the NLRA, to mark off an area for autonomous private ordering by labor and management, free from most forms of regulations by either the National Labor Relations Board or the States. *Lodge 76, Int'l Ass'n of Machinists v. Wisconsin Employment Relations Comm'n*, 427 U.S. 132, 140, 96 S.Ct. 2548, 2553, 49 L.Ed.2d 396 (1976) (hereinafter *Machinists*). *Local 24, Int'l Bhd. of Teamsters v. Oliver*, 358 U.S. 283, 295-296, 79 S.Ct. 297, 304-305, 3 L.Ed.2d 312 (1959) (hereinafter *Oliver*).

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[18] In some cases, the underlying collective bargaining agreements specify particular benefits; in other cases, the agreements prescribe only the total amount of the employers' contributions. Our conclusion that the NLRA does not preempt § 47B applies to both forms of agreement.

NLRB v. American Nat'l Ins. Co., 343 U.S. 395, 404, 72 S.Ct. 824, 829, 96 L.Ed. 1027 (1952). Apart from the limits set by Congress, both the economic tactics used during negotiations and the substantive terms of the resulting agreement are "left 'to be controlled by the free play of economic forces.'" *Machinists, supra* 427 U.S. at 140, 96 S.Ct. at 2553, quoting from *NLRB v. Nash-Finch Co.*, 404 U.S. 138, 144, 92 S.Ct. 373, 377, 30 L.Ed.2d 328 (1971). Therefore, when labor and management agree upon subjects of mandatory bargaining, the terms of their agreement "themselves become expressions of federal law, requiring premption of intrusive state law." *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 526, 101 S.Ct. 1895, 1907, 68 L.Ed.2d 403 (1981).[19]

Despite the breadth of its statements concerning the preemptive effect of collective bargaining agreements, the Supreme Court has recognized that Congress could not have intended to preempt "all local regulation that touches or concerns in any way the complex interrelationships between employees, employers and unions; obviously, much of this is left to the States." *Malone v.*

[19] The Supreme Court's preemption decisions under the NLRA fall into two categories. First, the Court has sometimes invalidated State action because it encroached upon the "primary jurisdiction" of the National Labor Relations Board over matters covered by the act. See, e.g., *San Diego Bldg. Trades Council v. Garmon*, 359 U.S. 236, 244-245, 79 S.Ct. 773, 779-780, 3 L.Ed.2d 775 (1959) (State injunction of picketing as an unfair labor practice). A second line of decisions, including those discussed in the text above, is based on implied Congressional intent to reserve to private resolution certain matters not covered by the regulatory provisions of the act. See, e.g., *New York Tel. Co. v. New York State Dep't of Labor*, 440 U.S. 519, 99 S.Ct. 1328, 59 L.Ed.2d 553 (1979); *Lodge 76, Int'l Ass'n of Machinists v. Wisconsin Employment Relations Comm'n*, 427 U.S. 132, 96 S.Ct. 2548, 49 L.Ed.2d 396 (1976); *Local 24, Int'l Bhd. of Teamsters v. Oliver*, 385 U.S. 283, 79 S.Ct. 297, 3 L.Ed.2d 312 (1959). In this second group of decisions, the Court has determined that the NLRA protects both choice of economic tactics, see, e.g., *Machinists, supra*, and choice of substantive terms, see, e.g., *Oliver, supra*, from State regulations.

White Motor Corp., 435 U.S. 497, 504, 98 S.Ct. 1185, 1190, 55 L.Ed.2d 443 (1978), quoting from *Amalgamated Ass'n of St., Elec. Ry. & Motor Coach Employees v. Lockridge*, 403 U.S. 274, 289, 91 S.Ct. 1909, 1919, 29 L.Ed.2d 473 (1971). See *Massachusetts Council of Constr. Employers, Inc. v. Mayor of Boston*, —— Mass. ——, —— —— ——, Mass.Adv.Sh. (1981) 2039, 2045-2046, 425 N.E.2d 346, cert. granted, —— U.S. ——, 102 S.Ct. 1273, 71 L.Ed.2d —— (1982). Accordingly, the Court has acknowledged a number of exceptions to NLRA preemption, each based upon the probability that Congress did not intend to displace a particular type of State regulation. Preemption will not be implied when Congress has indicated in other Federal legislation that State law should govern a certain area,[20] or when "the activity regulated [is] a merely peripheral concern of the [NLRA]." *San Diego Bldg. Trades Council v. Garmon*, 359 U.S. 236, 243, 79 S.Ct. 773, 779, 3 L.Ed.2d 775 (1959).[21] The

[20] In *Malone v. White Motor Corp.*, 435 U.S. 497, 98 S.Ct. 1185, 55 L.Ed.2d 443 (1978), the Court held that the NLRA did not preempt a State law governing pension funding, on the ground that a Federal statute, the predecessor of ERISA, demonstrated congressional intent to permit State regulation of the field. In *New York Tel. Co. v. New York State Dep't of Labor*, 440 U.S. 519, 99 S.Ct. 1328, 59 L.Ed.2d 553 (1979), the Court relied heavily upon the Social Security Act of 1935 in upholding a State law granting unemployment benefits to striking workers from revenue collected in part from the struck employers. *Id.* at 536-544, 99 S.Ct. at 1339-1343 (plurality opinion); *id.* at 547, 99 S.Ct. at 1344 (Blackmun, J., concurring).

[21] In *International Ass'n of Machinists v. Gonzales*, 356 U.S. 617, 78 S.Ct. 923, 2 L.Ed.2d 1018 (1957), cited by the Court after the statement quoted in the text, *supra*, the Court held that a State contract action against a union for wrongfully expelling a member was not preempted. See also *Massachusetts Elec. Co. v. Massachusetts Comm'n Against Discrimination*, 375 Mass. 160, 173-175, 375 N.E.2d 1192 (1978) (pregnancy benefits peripheral). The First Circuit, in *Wadsworth v. Whaland*, 562 F.2d 70, 79 (1st Cir. 1977), relied in part on the "peripheral concern" exception in holding that the NLRA did not preempt New Hampshire's mandatory mental health benefit statute, which is analogous to § 47B (see note 12 *supra*).

Court has also upheld State laws when "the regulated conduct touched interests . . . deeply rooted in local feeling and responsibility," *id.* at 244, 79 S.Ct. at 779,[22] and has suggested an exception for "local health or safety regulation[s]," *Oliver, supra* 358 U.S. at 297, 79 S.Ct. at 305.[23]

Section 47B affects health benefits, a subject of mandatory collective bargaining. See *Allied Chem. & Alkali Workers, Local No. 1 v. Pittsburgh Plate Glass Co., Chem. Div.*, 404 U.S. 157, 159, 92 S.Ct. 383, 387, 30 L.Ed.2d 341 (1971). It does not, however, regulate labor-management relations as such; its purpose is to protect public health,[24] and its method is regulation of insurers and in-

[22] The Court has applied this exception in upholding State authority to entertain tort actions arising out of labor disputes. See, e.g., *Linn v. United Plant Guard Workers, Local 114*, 383 U.S. 53, 60, 86 S.Ct. 657, 661-662, 15 L.Ed.2d 582 (1966). But see *Massachusetts Elec. Co. v. Massachusetts Comm'n Against Discrimination*, 375 Mass. 160, 173-175, 375 N.E.2d 1192 (1978).

[23] The Court has not actually applied this exception. It did, however, recognize the exception in a more recent decision involving a State law affecting the substantive terms of a collective bargaining agreement. *Malone v. White Motor Corp.*, 435 U.S. 497, 513 n.13, 98 S.Ct. 1185, 1194 n.13, 55 L.Ed.2d 443 (1978).

[24] A report of the Joint Committee on Insurance of the General Court, incorporated into the findings of the judge below, demonstrates that the Legislature was concerned with the spread of mental illness among workers and among the poor. In the committee's view, mental health insurance programs would encourage community-based, out-patient care and decrease the need for institutionalization. "Mental illness strikes indiscriminately among young and old, rich and poor. A need therefore exists for all people to be safeguarded against the high and sometimes crippling costs of professional mental health care today." General Court Joint Committee on Insurance, Advances in Health Insurance in Massachusetts 9 (1974). The defendants point to the committee's statement that "the organized worker had a higher rate of mental illness than the rich," and suggest that the committee was specifically concerned with labor relations. This statement, however (which was simply a description of the results of a Yale study), as well as other references to "workers," simply indicates the Legislature's recognition of the impact of mental illness on members of the working classes. It does not reveal an intent to alter the relative economic positions of organized labor and management. Cf. Cox, Labor Law Preemption Revisited, 85 Harv.L.Rev. 1337, 1352 (1972).

surance policies. Ordinarily, preemption depends upon the *effect* of State law upon NLRA policy, and the fact that a State law is enacted for neutral purposes and applies outside the employment relationship cannot save it from preemption. *San Diego Bldg. Trades Council v. Garmon*, 359 U.S. 236, 244, 79 S.Ct. 773, 779, 3 L.Ed.2d 775 (1959); *Oliver, supra* 358 U.S. at 297, 79 S.Ct. at 305. See *John Hancock Mut. Life Ins. Co. v. Commissioner of Ins.*, 349 Mass. 390, 400, 208 N.E.2d 516 (1965). See also *New York Tel. Co. v. New York State Dep't of Labor*, 440 U.S. 519, 550-551, 99 S.Ct. 1328, 1346-1347, 59 L.Ed.2d 553 (1979) (Blackmun, J., concurring, joined by Marshall, J.), 557-558, 99 S.Ct. 1349-1350 (Powell, J., dissenting, joined by Burger, C. J., and Stewart, J.). Nevertheless, the various exceptions described above suggest that the character and purpose of the State law may bear upon congressional intent to subordinate it to the NLRA's policy of free collective bargaining.

At least two of the exceptions recognized by the Court are relevant to the validity of § 47B. The first of these is the exception for public health laws, suggested by the Court's statement in *Oliver* that, "We have not here a case of a collective bargaining agreement in conflict with a local health or safety regulation; the conflict here is between the federally sanctioned agreement and state policy which seeks specifically to adjust relationships in the world of commerce." 358 U.S. at 297, 79 S.Ct. at 305. (See note 23 *supra*). Section 47B appears to us to be the type of permissible health regulation envisioned by the *Oliver* court. Section 47B is designed to solve a serious health problem, rather than to alter the bargaining positions of unions and employers. It is unlikely that

Congress intended, by enacting the NLRA, to bind the hands of State Legislatures with respect to problems such as mental health. And because § 47B is addressed to a statewide health problem not peculiar to employment relationships, its exemption will not open a door to State interference with the "free play of economic forces" between labor and management. See Cox, Labor Law Preemption Revisited, 85 Harv.L.Rev. 1337, 1352 (1972).

A second indication that Congress did not intend the NLRA to preempt laws such as § 47B can be found in another Federal statute, the McCarran-Ferguson Act. 15 U.S.C. §§ 1011-1015 (1976). *Wadsworth v. Whaland*, 562 F.2d 70, 79 n.44 (1st Cir. 1977); *Metropolitan Life Ins. Co. v. Whaland*, 119 N.H. 894, 905-906, 410 A.2d 635 (1979). See *Malone v. White Motor Corp.*, 435 U.S. 497, 98 S.Ct. 1185, 55 L.Ed.2d 443 (1978). See also note 20, *supra*. The McCarran-Ferguson Act establishes a congressional policy in favor of State regulation of insurance, and provides that "No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any state for the purpose of regulating the business of insurance." 15 U.S.C. § 1012(b) (1976). Although the purposes and effect of § 47B extend beyond regulation of insurance as such, the statute operates upon insurance and insurance policies. The McCarran-Ferguson Act does not contain a limiting definition of the term "business of insurance," see *SEC v. National Sec., Inc.*, 393 U.S. 453, 460, 89 S.Ct. 564, 568, 21 L.Ed.2d 668 (1969), and we do not believe that conflict between § 47B and the NLRA is serious enough to call for a narrow reading that would exclude § 47B from the act's protection.[25]

[25] The defendants point out that the McCarran-Ferguson Act provides that it should not be construed to affect the "application to the business of insurance of the [NLRA]." 15 U.S.C. § 1014 (1976). The most reasonable interpretation of this provision is that labor-management relations within insurance companies are subject to the NLRA. See *John Hancock Mut. Life Ins. Co. v. Commissioner of Ins.*, 349 Mass. 390, 398, 208 N.E.2d 516 (1965). The reading suggested by the defendants—that the implied preemptive effect of the NLRA extends to insurance regulation—is not a reasonable interpretation.

Finally, § 47B is not an absolute limit on the parties' freedom to negotiate the terms of employee health plans. The provisions of § 47B now before us apply to insurers. They do not mandate the inclusion of mental health benefits in employee plans unless the parties decide to purchase insurance. In view of the need to accommodate the "separate spheres of governmental authority preserved in our federalist system," *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 522, 101 S.Ct. 1895, 1905, 68 L.Ed.2d 403 (1981), we hesitate to extend the implied preemptive reach of the NLRA to such a law.

In sum, § 47B imposes some limits on the freedom of labor and management to bargain for health benefit terms, but does so only as an incident of the parties' decision to purchase insurance. At least two of the factors that the Supreme Court has identified as indicia of congressional intent to tolerate particular State legislation despite its effect on collective bargaining pertain to § 47B. Applying the principle that an "exercise of federal supremacy is not lightly to be presumed," *id.*, quoting *Schwartz v. Texas*, 344 U.S. 199, 203, 73 S.Ct. 232, 235, 97 L.Ed. 231 (1952), we conclude that the NLRA does not preempt § 47B.

5. *Application of § 47B to Policies Issued before 1976.*

The defendants' final contention is that § 47B does not and cannot apply to certain policies issued before its effective date (January 1, 1976), under which termination or renewal is at the option of the policyholder. These policies either do not permit the defendants to refuse to continue coverage, or permit refusal in limited circumstances

only. All of the policies, however, authorize the defendants to raise premium rates. The judge found that since January, 1976, the defendants have raised premium rates for almost all policies, and that in many instances the parties have altered benefit coverage as well. The judge ordered the defendants to provide the benefits required by § 47B under policies that were "issued prior to January 1, 1976, but . . . have been *altered or renewed through any change in premium or benefits*" (emphasis added). We interpret this order to require the defendants to provide benefits from the date of alteration under policies altered since January 1, 1976.

Section 47B applies by its terms to policies "issued or subsequently *renewed by agreement between the insurer and the policyholder*" after its effective date (emphasis added). We agree with the judge that "renew[al] by agreement" includes changes in benefits or premiums. A change in benefit coverage is in effect an agreement to a new policy, whatever the label applied by the parties. An insurer's decision to raise premiums presents a closer question; the insurer has not actually assented to continued coverage. Nevertheless, we believe that an insurer's adjustment of its compensation, coupled with the insured's acceptance of the new rates, amounts to renewal for purposes of § 47B. Section 47B is designed to enable as many Massachusetts residents as possible to receive mental health coverage. The provision limiting its application to policies newly issued or renewed is best read as a measure to ensure that insurance companies can adjust their rates to reflect the new risks imposed.

This application of § 47B does not conflict with the contract clause of the United States Constitution, art. 1, § 10. Although the Supreme Court has confirmed in recent decisions that the contract clause imposes substantial limits on the power of States to alter contractual obligations, it remains clear that the prohibition against impairment of contract is not absolute. See *Allied Structural Steel Co. v. Spannaus*, 438 U.S. 234, 98 S.Ct. 2716, 57 L.Ed.2d 727 (1978); *United States Trust Co. v. New Jersey*, 431 U.S. 1, 97 S.Ct. 1505, 52 L.Ed.2d 92 (1977). Private contract rights are subject to reasonable and necessary legislation in furtherance of important public interests, and legislative judgments concerning reasonableness and necessity are entitled to deference. *Allied Structural Steel Co. v. Spannaus, supra*, 438 U.S. at 244, 98 S.Ct. at 2722; *United States Trust Co. v. New Jersey, supra*, 431 U.S. at 22-23, 97 S.Ct. at 1517-1518. The Supreme Court has approached issues arising under the Contract Clause by assessing the relative weight of the impairment and the State's interest in enacting the impairing legislation. See *Allied Structural Steel Co. v. Spannaus, supra*, 438 U.S. at 244-250, 98 S.Ct. at 2722-2725.

The impairment wrought by § 47B is minimal. The defendants must provide insurance against a risk they did not assume in the original policies. The risk imposed by § 47B, however, does not affect the defendants retroactively; benefits are due only from the date on which the policies were issued or amended, and in no case before the effective date of the statute. Contrast *American Mfrs. Mut. Ins. Co. v. Commissioner of Ins.*, 347 Mass. 181, 372 N.E.2d 520 (1978) (mandatory premium rebates); *Allied Structural Steel Co. v. Spannaus, supra* (increased pension liability). Moreover, the defendants' policies permit them to counteract the new risk by raising premium rates. Contrast *Allied Structural Steel Co. v. Spannaus, supra* at 246-247, 98 S.Ct. at 2723-2724. Thus, the defendants—participants in a heavily regulated industry—[26] cannot complain of a serious interference with their reasonable expectations.

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[26] See *Allied Structural Steel Co. v. Spannaus*, 438 U.S. 234, 250, 98 S.Ct. 2716, 2765, 57 L.Ed.2d 727 (1978). See also G.L. c. 174-175F; *American Mfrs. Mut. Ins. Co. v. Commissioner of Ins.*, 374 Mass. 181, 193, 372 N.E.2d 520 (1978).

The State interest supporting § 47B—protection of the public health—is an important one, and the means selected to further it are reasonable. Section 47B applies generally to all insurers that issue policies to Massachusetts residents. Contrast *Allied Structural Steel Co. v. Spannaus, supra* at 250, 98 S.Ct. at 2725. Its application to policies altered after January 1, 1976, is reasonable and necessary to accomplish its objective of ensuring broad mental health coverage. Exclusion of such policies would permit insurance companies to avoid much of the effect of future insurance laws at no cost, by entering contracts characterized as perpetual, while retaining the right to raise premium rates. Without determining the full extent to which the State's interest in a broad application of mandatory benefit laws would justify impairment of private contracts, we believe that it overrides the minimal private interests here at stake.

We conclude that the application of § 47B at issue is severable from the application of § 47B that the parties have assumed to be invalid, and is not preempted by ERISA or the NLRA. With respect to policies issued since January 1, 1976, the judge correctly ordered the defendants to comply with § 47B from the date of issuance. With respect to policies issued before January 1, 1976, and altered or renewed through any change in premium or benefits after January 1, 1976, the judge correctly ordered the defendants to comply with the date of alteration.

Judgment affirmed.

APPENDIX E

COMMONWEALTH OF MASSACHUSETTS

SUPREME JUDICIAL COURT FOR THE COMMONWEALTH
AT BOSTON

March 24, 1982

In the Case No. SJC-2542

ATTORNEY GENERAL

vs.

THE TRAVELERS INSURANCE COMPANY

pending in the Superior Court Department of the Trial Court for the County of Suffolk, No. 35598.

ORDERED, that the following entry be made in the docket; viz., —

Judgment affirmed.

BY THE COURT,

/s/ Patrick M. Hurley,
Clerk

March 24, 1982.

See opinion on file.

APPENDIX F

COMMONWEALTH OF MASSACHUSETTS

SUPERIOR COURT

SUFFOLK, SS:

Civil Action No. 35598

COMMONWEALTH OF MASSACHUSETTS

v.

THE TRAVELERS INSURANCE COMPANY and
METROPOLITAN LIFE INSURANCE COMPANY

FINDINGS AND CONCLUSIONS PURSUANT TO MASS.R.CIV.P. 52

Based on all the credible evidence and the reasonable inferences therefrom, the Court makes the following findings:

1. This is an action brought by the Attorney General of the Commonwealth of Massachusetts requesting declaratory judgment and injunctive relief.

2. The plaintiff has sent and the defendants have each received notice, pursuant to G.L. c. 93A, § 4, of the intention of the Attorney General to file suit to enforce the provisions of G.L. c. 175, § 47B.

3. The Commonwealth of Massachusetts is a sovereign state of the United States represented by the Attorney General.

4. The Travelers Insurance Company is a corporation duly organized and existing under the laws of the State

of Connecticut, with a principal address at One Tower Square, Hartford, and is duly authorized to operate as a foreign insurance company in the Commonwealth.

5. Metropolitan Life Insurance Company is a corporation duly organized and existing under the laws of the State of New York, with a principal address at One Madison Avenue, New York, New York, and is duly authorized to operate as a foreign insurance company in the Commonwealth.

6. At all times relevant hereto, the defendant insurance companies have been authorized by the Commissioner of Insurance, pursuant to G.L. c. 175, § 150, to engage in the business of insurance in the Commonwealth.

7. The defendants each engage in the business of insurance in other states of the United States of America.

8. In the course of its business, each of the defendant insurance companies issues group insurance policies to policyholders which provide coverage for hospital and surgical expenses for subscribers of the group insurance policies who are residents of the Commonwealth of Massachusetts.

9. I find that many of the defendant insurance companies' group insurance policies are issued to implement employee welfare benefit plans.

10. General Laws Chapter 175, Section 47B was enacted on December 10, 1973, effective January 1, 1976, and provides as follows:

> Any blanket or general policy of insurance described in subdivision (A), (C), or (D) of section one hundred and ten*, which provides hospital expense and surgical expense insurance and which is

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* Section 110 refers to eligible groups which may be covered under group health insurance policies issued in Massachusetts.

issued or subsequently renewed by agreement between the insurer and the policyholder, within or without the commonwealth, during the period this provision is effective, or any policy of accident and sickness insurance as described in section one hundred and eight which provides hospital expense and surgical expense insurance and which is delivered or issued for delivery or subsequently renewed by agreement between the insurer and the policyholder in this commonwealth during the period that this provision is effective, or any employees' health and welfare fund which provides hospital expense and surgical expense benefits and which is promulgated or renewed to any person or group of persons in this commonwealth while this provision is effective shall, provide benefits for expense of residents of the commonwealth covered under any such policy or plan, arising from mental or nervous conditions as described in the standard nomenclature of the American Psychiatric Association which are at least equal to the following minimum requirements:

(a) In the case of benefits based upon confinement as an inpatient in a mental hospital under the direction and supervision of the department of mental health, or in a private mental hospital licensed by the department of mental health, the period of confinement for which benefits shall be payable shall be at least sixty days in any calendar year.

(b) In the case of benefits based upon confinement as an inpatient in a licensed or accredited general hospital, such benefits shall be no different than for any other illness.

(c) In the case of outpatient benefits, these shall cover, to the extent of five hundred dollars over a twelve-month period, services furnished (1) by a comprehensive health service organization, (2) by a licensed or accredited hospital (3) or subject to the

approval of the department of mental health services furnished by a community mental health center or other mental health clinic or day care center which furnishes mental health services or (4) consultation or diagnostic or treatment sessions, provided that such services under this clause are rendered by a psychotherapist or by a psychologist licensed under the provisions of chapter one hundred and twelve. For purposes of this clause "psychotherapist" shall mean a person fully licensed to practice medicine under the provisions of chapter one hundred and twelve, who devotes a substantial portion of his time to the practice of psychiatry.

11. The defendant insurance companies have issued numerous group insurance policies since January 1, 1976, to policyholders situated outside the Commonwealth of Massachusetts which provide benefits for hospital and surgical expenses to subscribers who are residents of the Commonwealth.

12. Certain of these policies do not provide coverage for Massachusetts resident subscribers for mental and nervous conditions mandated by G.L. c. 175, § 47B.

13. The defendant insurance companies have offered to issue group insurance policies to prospective policyholders outside the Commonwealth which will provide benefits for Massachusetts resident subscribers.

14. The defendant insurance companies have issued group insurance policies, effective prior to January 1, 1976, which contain no "renewal" clause among the policy terms. Such policies provide the defendants with the unilateral right to increase premiums on each such policy. The defendants and their policyholders may alter other policy terms and benefits by agreement. Such policies have been issued both within and outside the Commonwealth providing coverage to Massachusetts resident subscribers.

15. Since January 1, 1976, each of the defendants have increased the premiums, or altered the policy terms, or both, by agreement with the policyholders of the policies described in paragraphs 13 and 14.

16. Where the group insurance policies issued by the defendant insurance companies have been renewed or reissued since January 1, 1976, through the payment of increased or renewed premiums, or the alteration of policy benefits, the defendants have failed in each instance to provide to subscribers who are residents of the Commonwealth the coverage and benefits for mental and nervous conditions mandated by G.L. c. 175, § 47B.

17. The defendant insurance companies have denied coverage and benefits arising from mental and nervous conditions mandated by G.L. c.175, § 47B to Massachusetts resident subscribers of group insurance policies issued by them on various grounds, including:

(a) the policy contains no provision for renewal, and is subject to continuation at the option of the policyholder, and therefore is not subject to § 47B;

(b) the policy is issued to a qualified employee welfare benefit plan and, therefore, state law is preempted by ERISA;

(c) § 47B may not be applied extraterritorially to a policy issued outside of Massachusetts. The application of § 47B to a policy issued outside of Massachusetts violates the U.S. Constitution;

(d) where the application of § 47B would have the effect of altering benefits subject to collective bargaining, it is preempted by the National Labor Relations Act.

18. Metropolitan Life Insurance Company ("Metropolitan") has approximately 80 group insurance contracts in force which were issued outside of the Commonwealth of Massachusetts prior to January 1, 1976, and

which provide medical expense coverage to approximately 40,400 Massachusetts employees. To the extent data is available, the approximate number of employees residing within Massachusetts is 39,228 and outside of the Commonwealth of Massachusetts is substantially more. All actions with respect to the changing of premiums or benefits for those policies issued outside of Massachusetts took place outside of the Commonwealth of Massachusetts.

19. Metropolitan has approximately 28 group insurance contracts in force which were issued outside of the Commonwealth of Massachusetts on or after January 1, 1976, and which provide medical expense coverage to approximately 3,528 Massachusetts employees. To the extent data is available, the approximate number of employees residing within Massachusetts is 2,291 and outside of the Commonwealth of Massachusetts is substantially more. All actions with respect to the changing of premiums or benefits for those policies issued outside of Massachusetts took place outside of the Commonwealth of Massachusetts.

20. Metropolitan has approximately 33 group insurance contracts in force which were issued within the Commonwealth of Massachusetts prior to January 1, 1976, and which provide medical expense coverage to approximately 8,600 Massachusetts employees. To the extent data is available, the approximate number of employees residing within Massachusetts is 8,253 and outside of the Commonwealth of Massachusetts is approximately 6,852.

21. Metropolitan has approximately 28 group insurance contracts in force which were issued within the Commonwealth of Massachusetts on or after January 1, 1976, and which provide medical expense coverage to approximately 20,100 Massachusetts employees. To the extent data is available, the approximate number of employees residing within Massachusetts is 19,874 and outside of the Commonwealth of Massachusetts is 21,235.

22. The Travelers Insurance Company ("Travelers") has approximately 57 group insurance contracts in force which were issued outside of the Commonwealth of Massachusetts prior to January 1, 1976, and which provide medical expense coverage to approximately 14,000 Massachusetts employees. There are substantially more employees residing outside of the Commonwealth. All actions with respect to the changing of premiums or benefits for those policies issued outside Massachusetts took place outside the Commonwealth of Massachusetts.

23. Travelers has approvimately 27 group insurance contracts in force which were issued outside of the Commonwealth of Massachusetts on or after January 1, 1976, and which provide medical expense coverage to approximately 13,000 Massachusetts employees. There are substantially more employees residing outside of the Commonwealth. All actions with respect to the changing of premiums or benefits for those policies issued outside Massachusetts took place outside the Commonwealth of Massachusetts.

24. Travelers has approximately 2,150 group insurance contracts in force which were issued within the Commonwealth of Massachusetts and which provide medical expense coverage to approximately 45,000 Massachusetts employees. Of these contracts, an estimated 60% to 70% were issued prior to January 1, 1976.

25. Virtually all of Metropolitan's and Travelers' group insurance contracts in force providing medical expense coverage to Massachusetts employees were issued to provide benefits for employee benefit plans subject to the Employee Retirement Income Security Act of 1974 ("ERISA"). There are, however, a few such contracts issued to provide benefits for plans not subject to ERISA, such as church or government plans as defined in ERISA. With respect to all or virtually all Metropolitan policies, Metropolitan acts as the named fiduciary for the review of denied claims pursuant to ERISA. (For reference see Exhibit G.)

26. Metropolitan has approximately 49 group insurance contracts in force which were issued within the Commonwealth of Massachusetts on or after January 1, 1976, or which were issued within the Commonwealth of Massachusetts before January 1, 1976, and for which Metropolitan reserved the unilateral right to non-renew the contract, and which provide the benefits specified in G.L. c. 175, § 47B. Travelers has approximately 2,150 group insurance contracts in force which were issued within the Commonwealth and which provide the benefits specified in G.L. c. 175, § 47B. As a matter of policy and voluntary decision, the defendants and those policyholders have provided the benefits specified by G.L. c. 175, § 47B.

27. Certain of Metropolitan's and Travelers' group insurance contracts in force providing medical expense coverage to Massachusetts employees were issued to provide benefits for employee benefit plans which are the product of collective bargaining agreements negotiated subject to the National Labor Relations Act. Certain of these collective bargaining agreements prescribe the particular type and level of medical expense benefits to be afforded employees while others prescribe the level or amount of contributions to be afforded employees, and the particular group insurance contract which implements the terms of the collective bargaining agreement.

28. The preponderance of insurance policies affected by G.L. c. 175, § 48B have been issued to employers. A substantial number of these employers engage in business operations in other states as well as in Massachusetts, and have employees who live and work in such other states as well as in Massachusetts.

29. The Commonwealth is not seeking to enforce that part of G.L. c. 175, § 47B purporting to affect employee health and welfare plans directly.

30. The subject of health benefits, including mental health benefits, is a mandatory subject of collective bar-

gaining, as to which employers subject to the National Labor Relations Act have a duty to bargain.

31. More than 20% of the gross revenue from Metropolitan's trade or commerce is derived from transactions in interstate commerce. This is also true with respect to Travelers.

More than 20% of the gross revenue from Metropolitan's trade or commerce is derived from transactions in interstate commerce, excluding all transactions and actions which occur primarily and substantially within the Commonwealth. This is also true with respect to Travelers.

32. (a) The following is Metropolitan's standard group insurance contract "Renewal Privilege" provision generally in use for contracts issued from 1940 through 1975:

> RENEWAL PRIVILEGE—This Policy is issued for a period commencing with the date of issue and ending with the day immediately preceding on which last date and on each anniversary of which last date the Employer may renew this Policy for a further term of one year, provided (1) the number of Employees then insured hereunder for Personal Insurance is, in the case of Contributory Insurance, not less than seventy-five percent of the number of eligible Employees and, in the case of Non-Contributory Insurance, not less than the total number of eligible Employees, and provided, in either case, the number of Employees then insured hereunder for Personal Insurance is not less than fifty and (2) the number of Employees insured hereunder for Dependent Insurance, not less than seventy-five percent of the number of eligible Employees with Dependents and, in the case of Non-Contributory Insurance, not less than the total number of eligible Employees with Dependents. Such renewal is conditioned upon the payment of the premium then due as computed in the manner set forth in Section 16 hereof and based upon such premium rates as may then be determined by the Insurance Company.

(b) The following is Metropolitan's standard group insurance contract "Renewal Privilege" provision generally in use for contracts issued from 1976 through 1978. Certain contracts issued in 1975 also contained this provision.

> RENEWAL PRIVILEGE—This Policy may be renewed on any renewal date for a further period ending with the day immediately preceding the next renewal date, subject to the following provisions. Renewal is conditioned upon the payment of the premiums then due as computed in the manner set forth in Section 6 and based upon such premium rates as may then be determined by the Insurance Company.
>
> The Insurance Company reserves the right to decline to renew this Policy on any renewal date (a) if the number of Employees then insured for each type of insurance provided hereunder is less than 75%* of the number of Employees eligible for such insurance, or (b) if the number of Employees then insured hereunder is less than 50*.

(c) Metropolitan group insurance contracts issued in 1979 and thereafter generally do not include a provision labeled "Renewal Privilege". The following is Metropolitan's standard group contract "Discontinuance Of The Policy" provision generally included in group contracts issued in 1979 and thereafter:

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* Although the standard is 50, the number may be greater in certain contracts.

DISCONTINUANCE OF THE POLICY—Metropolitan will have the right to discontinue this Policy if less than 75% * of the eligible Employees are insured for each type of insurance. Metropolitan will also have such right if less than 50 ** Employees are insured. Such right may be exercised by Metropolitan only on the last day of the first Policy Period or on the day before any Premium Due Date which occurs after the last day of the first Policy Period. Notice, in writing, that this Policy is to be discontinued must be given to the Employer by Metropolitan. The notice must be given at least thirty-one days *** prior to the date this Policy is to be discontinued.

(d) Certain large groups have non-standard provisions in their group insurance contracts.

(1) The following "Renewal Privilege" provision forms the basis for the type of provision generally used for these groups:

RENEWAL PRIVILEGE—This Policy may be renewed on any renewal date for a further period ending with the day immediately preceding the next renewal date, subject to the following provisions. Renewal is conditioned upon the payment of the premiums then due as computed in the manner set forth in Section 6 and based upon such premium rates as may then be determined by the Insurance Company.

The Insurance Company reserves the right to decline to renew this Policy on any renewal date (a)

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* Change to 100% in the case of non-contributory insurance. Not less than 75% in the case of contributory insurance.

** Although the standard is 50, the number may be greater in certain contracts.

*** Although the standard is 31, the number may be changed to a longer period of up to 90 days in certain contracts.

if the number of Employees then insured for each type of insurance provided hereunder is less than 75% of the number of Employees eligible for such insurance, or (b) by giving at least ninety days prior written notice to the Employer.

(2) The following "Renewal Privilege" provision is an example of a provision presently contained in one such large group contract.

RENEWAL PRIVILEGE—This Policy is issued for a period commencing with the date of issue and ending with the day immediately preceding January 1, 1956, on which last date and on each anniversary of which last date the Employer may renew this Policy for a term of one year, except that the Insurance Company reserves the right to discontinue this Policy of December 31, 1960, or on the day preceding any subsequent renewal date by giving written notice to the Employer at least

33. With respect to virtually every one of the Metropolitan insurance contracts referred to in paragraphs 18 through 21 above, since January 1, 1976, the specific benefits provided pursuant to each particular contract and the premium paid under that contract have changed. With respect to virtually all of those insurance contracts, premiums have increased to account for inflation as well as expansions of the benefit package. It is common for the premiums of many of those contracts to be increased annually.

34. The Travelers standard form of group insurance policy, which relates to continuity and discontinuance of the policy and modification of the policy, including premium rate changes, has been virtually unchanged for the past 30 years. (For reference, see Exhibit J, and marked portions).

35. With respect to virtually every one of the Travelers insurance contracts referred to in paragraphs 22 and

23 above, since January 1, 1976 the specific benefits provided pursuant to each particular contract and the premium paid under that contract have changed. This is also true with respect to a substantial number of the Travelers insurance contracts referred to in paragraph 24 above. With respect to virtually all of those insurance contracts, premiums have increased to account for inflation as well as expansions of the benefit package. It is common for the premiums of many of those contracts to be increased annually.

36. Exhibits K and L are copies of current model or sample provisions for major medical expense benefits, including mental health benefits which are offered by Metropolitan and Travelers, respectively, to their policyholders. These provisions are used in the absence of policy holder requests for different provisions. A susbtantial number of times they are accepted by policyholders.

37. Certain of Metropolitan's and Travelers' insurance contracts have undergone changes in the areas of mental health, retirees or surgical benefits or in other related areas of benefits or eligibility. [Examples of such changes in the areas of mental health, retirees and surgical benefits are Exhibits M (Metropolitan) and N (Travelers) for reference].

38. With respect to G.L. c. 175, § 47B ("Section 47B"), there is: (a) substantial compliance by Metropolitan and substantial noncompliance by Travelers with Section 47B(a); (b) substantial compliance by Metropolitan and Travelers with Section 47B(b); and (c) substantial noncompliance by Metropolitan and Travelers with Section 47B(c).

39. With respect to certain of the Metropolitan and Travelers policies, each of the defendants has denied claims by Massachusetts residents for mental health care benefits that otherwise would have been paid if the polices had contained the provisions specified in G.L. c. 175, § 47B.

4. During the years 1976-1980, the Commonwealth of Massachusetts expended the following amounts for institutional mental health care, including care for alcoholism and drug abuse, and for all other mental and nervous disorders.

1976	1977	1978	1979	1980
87.6	86.8	93.1	96.4	88.4 Million

During the years of 1976-1980, the Commonwealth of Massachusetts expended the following amounts for community based mental health care, including care for alcoholism and drug abuse, and for all other mental and nervous disorders.

1976	1977	1978	1979	1980
26.8	36.8	45.1	60.5	103.3 Million

These funds are distributed to public and private community mental health centers, and other community mental health organizations, a substantial number of which derive a substantial portion of their revenue from third party insurance payments.

41. Virtually all claims submitted by or on behalf of Massachusetts residents pursuant to Metropolitan's group insurance contracts in force are received, reviewed, processed, and paid or denied outside of the Commonwealth of Massachusetts. In certain cases, Metropolitan policyholders with operations within the Commonwealth will be responsible for the actual transmission of claims from employees to Metropolitan.

42. With respect to certain of Travelers' group insurance contracts in force which were issued outside of the Commonwealth of Massachusetts, claims submitted by or on behalf of Massachusetts residents pursuant to such contracts are received, reviewed, processed and paid or denied outside of the Commonwealth. With respect to certain other of Travelers' contracts in force which were issued outside of the Commonwealth, including the con-

tract issued to G.T.E., some claims are received, reviewed, processed and paid or denied within the Commonwealth and some claims are received, reviewed, processed and paid or denied outside the Commonwealth.

43. The policy clauses referred to in paragraph 32(a) and (b) of these findings and the marked clauses referred to in paragraph 34 are contained in many of defendants' group insurance contracts in force covering Massachusetts residents and issued prior to January 1, 1976. Under these clauses, a policyholder may exercise its right to non-renew or discontinue its contract even if claims paid and expenses incurred by the insurer exceeded premium payments made to the insurer. This may leave the insurer with a net loss under the contract which it would be unable to recover from the policyholder. Even if the policyholder does not non-renew or discontinue the contract under those circumstances, the insurer will often be unable to recover the loss during the subquent year.

44. There are approximately 82 community mental health centers and clinics subject to reimbursement pursuant to G.L. c. 175, § 47B(c)(3).

45. The inpatient population of Massachusetts state mental hospitals has decreased from approximately 13,482 in 1969 to approximately 2,328 in 1980.

46. In general, the voluntary insurance market has been deficient in providing coverage for certain benefits, including treatment for mental or nervous conditions, due to the phenomenon of adverse selection as well as the fact that benefits for such coverage extend beyond the individual user.

47. Adverse selection operates where the insured individuals are able to identify themselves as good or bad risks. This is often true for mental or nervous conditions. Insurance companies must price coverage at the average or expected cost of treatment. However, if good

risks (i.e. those individuals who do not perceive a need for the particular benefit being offered) avoid the coverage, the insurance company no longer is providing insurance to an average group, since it is dominated by bad risks (i.e. those who are in need of the particular benefit). Where the legislature mandates coverage for mental and nervous conditions, it facilitates consumer preferences and produces a normal competitive market. Thus, each person is able to receive coverage at the "average" price for the group, thus spreading the risk.

48. Mental illness is a major and exceedingly costly national health problem. The direct costs of treatment are staggering, yet they are exceeded by indirect costs. Indirect costs are the income or income-equivalent losses which result from deaths due to mental illness, total disability due to mental illness and the loss of productive time to those individuals who are institutionalized or who utilize outpatient therapy.

49. At a total cost of about $15 billion, mental illness is dealt with by means other than treatment by health personnel, including police, welfare and other social agencies. Taxes support social services at V.A. hospitals, taxes and insurance premiums together pay for 90% of hospital expenses and 70% of physicians' charges. These social expenditures are made collectively.

50. The impact of G.L. c. 175, § 47B will result in additional premium costs. However, this impact is only manifested by a shift in the source of payment for treatment of mental or nervous conditions. There is no data by which shifts in costs and additional costs can be separated.

51. The important social benefits which accrue from the increased availability of treatment for mental or nervous conditions, include increases in employment productivity and decreases in utilization of other non-psychiatric medical care.

52. The legislative intent behind the enactment of G.L. c. 175, § 47B was reported by the Joint Insurance Committee of the General Court, as follows:

a. Mental illness strikes indiscriminately among young and old, rich and poor. A need therefore exists for all people to be safeguarded against the high and sometimes crippling costs of professional mental health care today.

b. It has been demonstrated that mental health insurance is insurable at a reasonable cost for groups. Blue Cross indicates only a slight increase for non-group subscribers over what group members now pay for mental health benefits.

c. There is a growing trend in this state towards community mental health care. No longer will institutionalization be the answer for the majority of the mentally ill.

Instead, out-patient treatment delivered close to home at early stages will be tomorrow's answer. In order to enlarge this system and make it available to millions of Massachusetts residents, mental health insurance must be mandatory in our health insurance policies sold in this commonwealth.

d. Studies show that people who have mental health insurance do not abuse it, even with no limit to the number of services and with no co-payment. Mental health benefits are moderately utilized.

e. Mental health insurance significantly reduces the amount of non-psychiatric medical care to a given population. This indicates that people who do not have mental health insurance either wait until their illness physically affects them, or are being treated in a manner not appropriate to the illness.

f. There is a great potential for increased revenue to the commonwealth, because of 3rd party payments from insurance companies. Connecticut in their first year of

their mental health insurance bill realized an increase in third party payments in the amount of 1.5 million dollars—an increase of approximately sixty percent. If Massachusetts had proportionately the same success with third party payments as Connecticut, a sixty percent increase could mean an additional six million dollars in revenue. Although this increase is a very optimistic one, the potential for increased revenue is there.

g. The most humanitarian reason for mandatory mental health insurance against the mentally ill is ended. It means that the state, by making mental health insurance mandatory on all policies, officially recognized that mental illness is a health problem that all must be protected against. No longer will the mentally ill be forced to go to a public institution instead of a local private institution because they could not get mental health insurance.

53. Since January 1, 1976, the effective date of G.L. c. 175, § 47B, a number of observable changes have occurred in the market for treatment of mental and nervous conditions in Massachusetts.

a. There has been a dramatic shift from in-patient to out-patient delivery of treatment for mental and nervous conditions.

b. The number of providers of out-patient treatment for mental and nervous conditions has increased.

c. The socioeconomic mix of persons receiving treatment for mental and nervous conditions has changed dramatically. Whereas these services were provided on an out-patient basis primarily to upper middle class and wealthy clients prior to January 1, 1976, a large percentage of the total today are poor, working and middle class persons.

54. The defendants failed to seek declaratory or other relief in this matter.

55. No credible evidence was produced regarding the additional premium cost impact of the Massachusetts mandated benefit statute. Specifically, evidence which would have substantiated the fact that, the defendants in providing medical health benefits to Massachusetts residents, would be unable to absorb the annual $500 cost of providing a minimum mental health benefit mandated by G.L. c. 175, § 47B.

56. There is a direct correlation between the premium cost impact of a mandated benefit statute and the recovery limit. Section 47B provides for a minimum recovery of $500. It is a logical inference that the limit of $500 would have a direct relationship to a restricted increase, if any, in premium cost.

57. Mandated benefit laws do impose an administrative burden. However, the diversity of eligibility requirements for each state for example, would not be any more complex or burdensome to interstate commerce than various other diverse multi-state regulatory schemes such as workmen's compensation laws.

58. There is no credible evidence that a single plan in the United States has gone bankrupt because of its compliance with a mandated benefit statute.

59. There is no credible evidence which establishes the amount of additional premium cost which would be incurred if each of the group policies issued by these defendants in fact complied with G.L. c. 175, § 47B.

60. There is no credible evidence which establishes the amount of additional premium which would be incurred if the policies issued by these defendants provided the minimum mental health benefits required by the few mandated benefits statutes which apply extraterritorily to policies issued out of state covering employees or residents within the state.

61. There is no credible evidence which establishes the amount of additional premium which would be required

to provide equal mandatory minimum benefits of various kinds to all persons covered by group insurance contracts nationally.

62. There is no credible evidence that the potential cost impact of § 47B has forced any policyholder of any insurance which has previously complied with § 47B to discontinue such coverage and become a self-insurer.

63. There is no credible evidence that the trend towards self-insurance is more pronounced in Massachusetts by virtue of the enactment of Section 47B. This trend has permeated various types of insurance mechanisms due to the sharply escalating prices for various types of insurance coverage. A few examples include health, product liability and professional liability insurance.

64. The subject of health benefits, including mental health benefits, is a mandatory subject of collective bargaining, as to which employers subject to the National Labor Relations Act have a duty to bargain.

65. It is common for collective bargaining agreements to specifically reserve to the employer the right to alter any portion of the agreement to comply with any applicable change in state or federal law.

66. Collective bargaining agreements differ in many respects from state to state or from bargaining unit to bargaining unit because of the differences in state and local law.

67. There is no credible evidence that the mandated mental and nervous condition benefit statutes are more disruptive to the collective bargaining process than were statutes, such as G.L. c. 151(b), § 5, mandating coverage for pregnancy-related disabilities on the same basis as for other disabilities, prior to the Title VII amendments of the Civil Rights Act in 1979.

68. Among the health benefits which are a mandatory subject of collective bargaining are benefits for treatment

of mental and nervous conditions as well as benefits for pregnancy-related disabilities.

69. Assuming that each state enacted mandated benefits laws and further that eligibility requirements were different for each state, there is no credible evidence that this diversity would be any more complex or burdensome to interstate commerce than various other diverse multi-state regulatory schemes such as workmen's compensation laws.

CONCLUSIONS

70. The acts of the Legislature are presumed to be constitutional. *Commonwealth* v. *Henry's Drywall Co. Inc.*, 366 Mass. 539, 541. Thus, the defendants bear the heavy burden of showing an invalid exercise of legislative power or an impermissible infringement of its property rights. *Consolidated Cigar Corp.* v. *Department of Public Health*, 372 Mass. 844, 851.

71. The McCarren-Ferguson Act preserves state insurance statutes from attack under the Commerce Clause. *Prudential Insurance Co.* v. *Benjamin*, 328 U.S. 408, 431 (1946). Congress has declared that uniformity of regulation is not required in reference to the business of insurance. Thus, Congress recognized that the variations in state regulation of interstate insurance transactions would impose a burden on commerce which otherwise may be subject to challenge under the Commerce Clause. *Lewis* v. *B. T. Investment Managers, Inc.*, 48 U.S.L.W. 4638 (June 9, 1980). But if the Commerce Clause was applicable, the state's interest in substantial health benefits for its residents, the fact that the statute applies evenhandedly to policies issued within and outside of the state, the incidential effect on interstate commerce, the fact that a state has a legitimate interest in relieving itself of a portion of the financial burden of treatment for mental and nervous conditions all combined, give the state the right to exercise its general police powers in the

manner of this legislation. *Metropolitan Life Insurance Company* v. *Whaland*, —— N.H. —— (December 28, 1979); *Wadsworth* v. *Whaland*, 562 F.2d 70 (1st Cir. 1977), *cert. denied*, 435 U.S. 980 (1978).

72. Massachusetts may regulate interstate insurance transactions under the due process clause where a legitimate state interest exists in the substance of the transaction. A state may subject out-of-state insurance transactions to its laws where the state has a legitimate interest in regulation. As long as a legitimate state interest exists, the state also has sufficient contacts with the transaction to justify state action. *Osborn* v. *Ozlin*, 310 U.S. 53 (1940). It is obvious that the licensing of the defendant companies is sufficient contact to warrant the legislation. The state has a substantial interest in the business of insurance of its people.

73. The Full Faith and Credit Clause has no application where a state has a direct interest in an interstate insurance transaction. *Watson* v. *Employers Liability Assurance Corp.*, 348 U.S. 66 (1954).

74. G.L. c. 175, § 47B is not preempted by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001 *et seq.*; the National Labor Relations Act (NLRA), 29 U.S.C. § 141 *et seq.*; and the Railway Labor Act, 29 U.S.C. § 151 *et seq.*; *Wadsworth* v. *Whaland*, 562 F.2d 70 (1st Cir. 1977), *cert. denied*, 435 U.S. 980 (1978).

75. G.L. c. 175, § 47B is not a law impairing the obligation of contracts repugnant to the Constitution of the United States. The Contract Clause only protects impairment of contracts issued prior to January 1, 1976, the effective date of § 47B. Both defendant companies have issued group insurance policies that provide medical coverage to Massachusetts employees and residents since the date of the enactment of said legislation.

76. § 47B does not impair existing contracts because defendant insurance companies have formed new con-

tracts originally issued prior to January 1, 1976. The defendant insurance companies have issued complex and elaborate riders which increase premium charges and in some cases have changed the constituency of the employee and dependent groups insured by the original insurance policy. These riders indicate the making of a new contract.

There are five essential elements to an insurance contract: (a) subject matter of the insurance; (b) risk insured against; (c) amount of insurance; (d) duration of risk; (e) premium. *Mann* v. *Charter Oak Fire Insurance Company*, 196 F.Supp. 604, 608 (D.C. Ark. 1961), *aff'd* 304 F.2d 166 (8th cir. 1962). An increase in premiums or a change in any of the remaining essential terms constitutes a new contract. *Ocean Ace and Guaranty Corp.* v. *Combined Locks Paper Co.*, 15 N.W. 156 (Wisc. 1916); 1 Couch on Insurance 2d, § 4.27.

77. The policies have been renewed within the meaning of the statute. Specifically, Metropolitan's policies until 1979 actually contained renewal clauses. Travelers' policies list an anniversary date. Both terms allow the insurer to demand higher premiums in exchange for continuing the policy. This constitutes the issuance of a new contract to which intervening regulatory legislation can be constitutionally applied. *Moore* v. *Metropolitan Life Insurance Co.*, 33 N.Y. 2d 304, 307 N.E. 2d 554 (1973).

78. Any impairment to insurance contracts issued prior to January 1, 1976, caused by § 47B is constitutionally permissible. The act serves a legitimate public purpose and more importantly, the purposes of the act are achieved in a reasonable manner. *Allied Structural Steel Co.* v. *Spannaus*, 438 U.S. 234, 244-245 (1978); *Home Building & Loan Assn.* v. *Blaisdell*, 290 U.S. 398 (1934). The demonstrated public need for basic mental health insurance has been addressed with a reasonable

and precise legislative response. Thus, any impairment of contracts and possible burden on insurers is clearly outweighed by the public interest.

79. The fact that the statute applies to the uninsured and to the insured plans and also that the Commonwealth states for the record that the uninsured provision is unenforceable, alone, does not make the statute unconstitutional. By not striking down the total statute and allowing "the insured" portion to stand, we are preserving as much of the legislative intent as is possible, in a fair application of constitutional principles. *Lowell v. Kowalski*, Mass. Adv. Sh. (1980) 1243, 1250; *see also*, 2 C. Sands, Sutherland Statutory Construction, § 44.17, 44.18 (1973); *see also*, *Commonwealth* v. *Baird*, 355 Mass. 746. I uphold the remainder of the statute other than that which is inapplicable, thus "the uninsured" portion, because the statute without the uninsured thrust still has independent force. *Del Duca* v. *Town Administrator of Methuen*, 368 Mass. 1.

80. I rule that the acts of the defendants are not a violation of G.L. c. 93A, § 2(a), and I further rule that the acts of the defendants are not unfair methods of competition nor unfair or deceptive acts or practices. While the plaintiff argues that *Shubach* v. *Household Finance Co.*, Mass. Adv. Sh. (1978) 1153 applies, I do not agree.

Therefore, I order that the defendants are permanently enjoined from the failure to provide benefits for expense for treatment of mental and nervous conditions, as required by G.L. c. 175, § 47B, for residents of the Commonwealth who are subscribers of group insurance policies, issued by the defendants within or without the Commonwealth since January 1, 1976, or issued prior to January 1, 1976, but which have been altered or renewed through any change in premium or benefits.

This Judgment shall be implemented as follows:

1. Where a group insurance policy issued by either of the defendants has not provided the benefits required

by G.L. c. 175, § 47B at any time since January 1, 1976, the defendants shall, within 30 days of this Judgment provide to each such policyholder copies of a notice of benefit changes, and shall provide that such notices be posted by the policyholder in a conspicuous manner and in a sufficient number of locations to provide notice to policy subscribers of the benefit changes implemented by this Judgment. Such notice shall contain the following language in at least 24 point type:

NOTICE OF BENEFIT FOR MASSACHUSETTS RESIDENTS

IN ACCORDANCE WITH A FINAL JUDGMENT ENTERED BY THE SUPERIOR COURT OF MASSACHUSETTS, THE BENEFITS PROVIDED BY (NAME OF GROUP INSURANCE POLICY OR PLAN) FOR MENTAL OR NERVOUS CONDITIONS HAVE BEEN CHANGED FOR MASSACHUSETTS RESIDENTS ONLY. IN ACCORDANCE WITH THE COURT'S ORDER, YOUR POLICY WILL PAY FOR INPATIENT AND OUTPATIENT SERVICES FOR TREATMENT OF MENTAL AND NERVOUS CONDITIONS, SUBJECT TO ANY APPLICABLE DEDUCTIBLE OR COINSURANCE PROVISIONS IN THE POLICY. IN THE CASE OF OUTPATIENT SERVICES, YOU ARE COVERED BY 1) A COMPREHENSIVE HEALTH SERVICE ORGANIZATION; 2) A LICENSED HOSPITAL; 3) A LICENSED COMMUNITY MENTAL HEALTH CENTER, MENTAL HEALTH CLINIC OR DAY CARE CENTER WHICH FURNISHES MENTAL HEALTH SERVICES; 4) A LICENSED PSYCHOLOGIST OR PSYCHIATRIST. THIS CHANGE IS APPLICABLE TO ANY CLAIM FOR SUCH SERVICES PROVIDED SINCE JANUARY 1, 1976.

IF YOU RECEIVED TREATMENT FOR A MENTAL OR NERVOUS CONDITION SINCE JANUARY 1, 1976, FOR WHICH YOU DID NOT RECEIVE PAYMENT UNDER (NAME OF GROUP INSURANCE POLICY OR PLAN), YOU MAY FILE A CLAIM. YOUR CLAIM WILL BE EXAMINED AND IF THE BENEFIT CHANGES DESCRIBED IN THIS NOTICE APPLY, YOUR CLAIM WILL BE PAID.

The defendants further shall publish within 60 days in at least 3 mental health treatment journals of general circulation the following notice to providers of services who have made direct claims to the defendants, but who have not received reimbursement due to the defendant's noncompliance with G.L. c. 175, § 47B:

IN ACCORDANCE WITH A FINAL JUDGMENT ENTERED BY THE SUPERIOR COURT OF MASSACHUSETTS, THE BENEFITS PROVIDED BY ANY POLICIES ISSUED BY THE TRAVELERS INSURANCE COMPANY AND THE METROPOLITAN LIFE INSURANCE COMPANY FOR MENTAL OR NERVOUS CONDITIONS HAVE BEEN CHANGED FOR MASSACHUSETTS RESIDENTS ONLY. IN ACCORDANCE WITH THE COURT'S ORDER, THESE POLICIES WILL PAY FOR INPATIENT AND OUTPATIENT SERVICES FOR TREATMENT OF MENTAL AND NERVOUS CONDITIONS, SUBJECT TO ANY APPLICABLE DEDUCTIBLE OR COINSURANCE PROVISIONS IN THE POLICY. IN THE CASE OF OUTPATIENT SERVICES, SUBSCRIBERS ARE COVERED TO THE EXTENT OF $500 PER YEAR FOR TREATMENT PROVIDED BY 1) A COMPREHENSIVE HEALTH SERVICE ORGANIZATION; 2) A LICENSED HOSPITAL; 3) A LICENSED COMMUNITY MENTAL HEALTH CENTER, MENTAL HEALTH CLINIC OR DAY

CARE CENTER WHICH FURNISHES MENTAL HEALTH SERVICES; 4) A LICENSED PSYCHOLOGIST OR PSYCHIATRIST. THIS CHANGE IS APPLICABLE TO ANY CLAIM FOR SUCH SERVICES PROVIDED SINCE JANUARY 1, 1976.

IF ANY QUALIFIED PROVIDER RENDERED TREATMENT FOR A MENTAL OR NERVOUS CONDITION SINCE JANUARY 1, 1976, FOR WHICH THE PROVIDER SUBMITTED A CLAIM WHICH WAS NOT ACCEPTED, THE CLAIM MAY BE RESUBMITTED. THE CLAIM WILL BE EXAMINED AND IF THE BENEFIT CHANGES DESCRIBED IN THIS NOTICE APPLY, THE CLAIM WILL BE PAID.

2. Commencing 30 days from the effective date of this order, the defendants shall pay expenses for benefits required by G.L. c. 175, § 47B on claims submitted by subscribers for services rendered at any time since January 1, 1976.

/s/ Peter F. Brady
PETER F. BRADY
Justice of the Superior Court

Entered: Oct. 17, 1980

APPENDIX G

COMMONWEALTH OF MASSACHUSETTS
SUPERIOR COURT

SUFFOLK, ss:

Civil Action No. 35598

COMMONWEALTH OF MASSACHUSETTS,
Plaintiff

v.

THE TRAVELERS INSURANCE COMPANY

—and—

METROPOLITAN LIFE INSURANCE COMPANY,
Defendants

JUDGMENT ON FINDINGS BY THE COURT

This action came on for hearing before the Court, Brady, J., presiding, and the issues having been duly heard and findings having been duly rendered; it is ordered and adjudged as follows:

1. That the defendants are permanently enjoined from the failure to provide benefits for expense for treatment of mental and nervous conditions, as required by G.L. c. 175, § 47B, for residents of the Commonwealth who are subscribers of group insurance policies, issued by the defendants within or without the Commonwealth since January 1, 1976, or issued prior to January 1, 1976, but which have been altered or renewed through any change in premium or benefits.

This Judgment shall be implemented as follows:

1. Where a group insurance policy issued by either of the defendants has not provided the benefits required by

G.L. c. 175, § 47B at any time since January 1, 1976, the defendants shall, within 30 days of this Judgment provide to each such policyholder copies of a notice of benefit changes, and shall provide that such notices be posted by the policyholder in a conspicuous manner and in a sufficient number of locations to provide notice to policy subscribers of the benefit changes implemented by this Judgment. Such notice shall contain the following language in at least 24 point type:

NOTICE OF BENEFIT FOR MASSACHUSETTS RESIDENTS

IN ACCORDANCE WITH A FINAL JUDGMENT ENTERED BY THE SUPERIOR COURT OF MASSACHUSETTS, THE BENEFITS PROVIDED BY (NAME OF GROUP INSURANCE POLICY OR PLAN) FOR MENTAL OR NERVOUS CONDITIONS HAVE BEEN CHANGED FOR MASSACHUSETTS RESIDENTS ONLY. IN ACCORDANCE WITH THE COURT'S ORDER, YOUR POLICY WILL PAY FOR INPATIENT AND OUTPATIENT SERVICES FOR TREATMENT OF MENTAL AND NERVOUS CONDITIONS, SUBJECT TO ANY APPLICABLE DEDUCTIBLE OR COINSURANCE PROVISIONS IN THE POLICY. IN THE CASE OF OUTPATIENT SERVICES, YOU ARE COVERED BY 1) A COMPREHENSIVE HEALTH SERVICE ORGANIZATION; 2) A LICENSED HOSPITAL; 3) A LICENSED COMMUNITY MENTAL HEALTH CENTER, MENTAL HEALTH CLINIC OR DAY CARE CENTER WHICH FURNISHED MENTAL HEALTH SERVIES; 4) A LICENSED PSYCHOLOGIST OR PSYCHIATRIST. THIS CHANGE IS APPLICABLE TO ANY CLAIM FOR SUCH SERVICES PROVIDED SINCE JANUARY 1, 1976.

IF YOU RECEIVED TREATMENT FOR A MENTAL OR NERVOUS CONDITION SINCE

JANUARY 1, 1976, FOR WHICH YOU DID NOT RECEIVE PAYMENT UNDER (NAME OF GROUP INSURANCE POLICY OR PLAN), YOU MAY FILE A CLAIM. YOUR CLAIM WILL BE EXAMINED AND IF THE BENEFIT CHANGES DESCRIBED IN THIS NOTICE APPLY, YOUR CLAIM WILL BE PAID.

The defendants further shall publish within 60 days in at least 3 mental health treatment journals of general circulation the following notice to providers of services who have made direct claims to the defendants, but who have not received reimbursement due to the defendant's noncompliance with G.L. c 175 § 48B:

IN ACCORDANCE WITH A FINAL JUDGMENT ENTERED BY THE SUPERIOR COURT OF MASSACHUSETTS, THE BENEFITS PROVIDED BY ANY POLICIES ISSUED BY THE TRAVELERS INSURANCE COMPANY AND THE METROPOLITAN LIFE INSURANCE COMPANY FOR MENTAL OR NERVOUS CONDITIONS HAVE BEEN CHANGED FOR MASSACHUSETTS RESIDENTS ONLY. IN ACCORDANCE WITH THE COURT'S ORDER, THESE POLICIES WILL PAY FOR INPATIENT AND OUTPATIENT SERVICES FOR TREATMENT OF MENTAL AND NERVOUS CONDITIONS, SUBJECT TO ANY APPLICABLE DEDUCTIBLE OR COINSURANCE PROVISIONS IN THE POLICY. IN THE CASE OF OUTPATIENT SERVICES, SUBSCRIBERS ARE COVERED TO THE EXTENT OF $500 PER YEAR FOR TREATMENT PROVIDED BY 1) A COMPREHENSIVE HEALTH SERVICE ORGANIZATION; 2) A LICENSED HOSPITAL; 3) A LICENSED COMMUNITY MENTAL HEALTH CENTER, MENTAL HEALTH CLINIC OR DAY CARE CENTER WHICH FURNISHES MENTAL HEALTH SERV-

ICES; 4) A LICENSED PSYCHOLOGIST OR PSYCHIATRIST. THIS CHANGE IS APPLICABLE TO ANY CLAIM FOR SUCH SERVICES PROVIDED SINCE JANUARY 1, 1976.

IF ANY QUALIFIED PROVIDER RENDERED TREATMENT FOR A MENTAL OR NERVOUS CONDITION SINCE JANUARY 1, 1976, FOR WHICH THE PROVIDER SUBMITTED A CLAIM WHICH WAS NOT ACCEPTED, THE CLAIM MAY BE RESUBMITTED. THE CLAIM WILL BE EXAMINED AND IF THE BENEFIT CHANGES DESCRIBED IN THIS NOTICE APPLY, THE CLAIM WILL BE PAID.

2. Commencing 30 days from the effective date of this order, the defendants shall pay expenses for benefits required by G.L. c. 175, § 48B on claims submitted by subscribers for services rendered at any time since January 1, 1976, on policies.

DATED AT BOSTON, MASSACHUSETTS, THIS 17TH DAY OF OCTOBER, 1980.

Form of Judgment Approved:

MICHAEL JOSEPH DONOVAN,
Clerk of Court

/s/ Peter F. Brady
Associate Justice of the Superior Court

By:
Assistant Clerk

APPENDIX H

COMMONWEALTH OF MASSACHUSETTS
SUPERIOR COURT

SUFFOLK, ss:

Civil Action No. 35598

COMMONWEALTH OF MASSACHUSETTS,
Plaintiff

v.

THE TRAVELERS INSURANCE COMPANY

—and—

METROPOLITAN LIFE INSURANCE COMPANY,
Defendants

JUDGMENT ON FINDINGS BY THE COURT

This action came on for hearing before the Court, Brady, J., presiding, and the issues having been duly heard and findings having been duly rendered; it is ordered and adjudged as follows:

1. That the defendants are permanently enjoined from the failure to provide benefits for expense for treatment of mental and nervous conditions, as required by G.L. c. 175, § 47B, for residents of the Commonwealth who are subscribers of group insurance policies, issued by the defendants within or without the Commonwealth since January 1, 1976, or issued prior to January 1, 1976, but which have been altered or renewed through any change in premium or benefits.

This Judgment shall be implemented as follows:

1. Where a group insurance policy issued by either of the defendants has not provided the benefits required by G.L. c. 175, § 47B at any time since January 1, 1976, the defendants shall, on or before December 17, 1980, provide to each such policyholder (other than policyholders whom

the defendants previously provided with copies of the notice of benefit changes required by this Court's preliminary injunction entered August 28, 1979) copies of a notice of benefit changes, and shall provide that such notices be posted by the policyholder in a conspicuous manner and in a sufficient number of locations to provide notice to policy subscribers of the benefit changes implemented by this Judgment. Such notice shall contain the following language in at least 24 point type:

NOTICE OF BENEFIT FOR MASSACHUSETTS RESIDENTS

IN ACCORDANCE WITH A FINAL JUDGMENT ENTERED BY THE SUPERIOR COURT OF MASSACHUSETTS, THE BENEFITS PROVIDED BY (NAME OF GROUP INSURANCE POLICY OR PLAN) FOR MENTAL OR NERVOUS CONDITIONS HAVE BEEN CHANGED FOR MASSACHUSETTS RESIDENTS ONLY. IN ACCORDANCE WITH THE COURT'S ORDER, YOUR POLICY WILL PAY FOR INPATIENT AND OUTPATIENT SERVICES FOR TREATMENT OF MENTAL AND NERVOUS CONDITIONS, SUBJECT TO ANY APPLICABLE DEDUCTIBLE OR COINSURANCE PROVISIONS IN THE POLICY. IN THE CASE OF OUTPATIENT SERVICES, YOU ARE COVERED TO THE EXTENT OF $500 PER YEAR FOR TREATMENT PROVIDED BY 1) A COMPREHENSIVE HEALTH SERVICE ORGANIZATION; 2) A LICENSED HOSPITAL; 3) A LICENSED COMMUNITY MENTAL HEALTH CENTER, MENTAL HEALTH CLINIC OR DAY CARE CENTER WHICH FURNISHED MENTAL HEALTH SERVICES; 4) A LICENSED PSYCHOLOGIST OR PSYCHIATRIST. THIS CHANGE IN COVERAGE IS APPLICABLE TO ANY CLAIM FOR SUCH SERVICES PROVIDED SINCE (INSERT APPLICABLE EFFECTIVE DATE OF CHANGE).

IF YOU RECEIVED TREATMENT FOR A MENTAL OR NERVOUS CONDITION SINCE (INSERT APPLICABLE EFFECTIVE DATE OF CHANGE), FOR WHICH YOU DID NOT RECEIVE PAYMENT UNDER (NAME OF GROUP INSURANCE POLICY OR PLAN), YOU MAY FILE A CLAIM. YOUR CLAIM WILL BE EXAMINED AND IF THE BENEFIT CHANGES DESCRIBED IN THIS NOTICE APPLY, YOUR CLAIM WILL BE PAID.

The defendants further shall publish on or before January 19, 1981 in at least 3 mental health treatment journals of general circulation the following notice to providers of services who have made direct claims to the defendants, but who have not received reimbursement due to the defendant's noncompliance with G.L. c. 175 § 47B:

IN ACCORDANCE WITH A FINAL JUDGMENT ENTERED BY THE SUPERIOR COURT OF MASSACHUSETTS, THE BENEFITS PROVIDED BY ANY POLICIES ISSUED BY THE TRAVELERS INSURANCE COMPANY AND THE METROPOLITAN LIFE INSURANCE COMPANY FOR MENTAL OR NERVOUS CONDITIONS HAVE BEEN CHANGED FOR MASSACHUSETTS RESIDENTS ONLY. IN ACCORDANCE WITH THE COURT'S ORDER, THESE POLICIES WILL PAY FOR INPATIENT AND OUTPATIENT SERVICES FOR TREATMENT OF MENTAL AND NERVOUS CONDITIONS, SUBJECT TO ANY APPLICABLE DEDUCTIBLE OR COINSURANCE PROVISIONS IN THE POLICY. IN THE CASE OF OUTPATIENT SERVICES, SUBSCRIBERS ARE COVERED TO THE EXTENT OF $500 PER YEAR FOR TREATMENT PROVIDED BY 1) A COMPREHENSIVE HEALTH SERVICE ORGANIZATION; 2) A LICENSED HOSPITAL; 3) A LICENSED COMMUNITY MENTAL HEALTH CENTER, MENTAL HEALTH CLINIC OR DAY

CARE CENTER WHICH FURNISHES MENTAL HEALTH SERVICES; 4) A LICENSED PSYCHOLOGIST OR PSYCHIATRIST. THIS CHANGE IS APPLICABLE TO CLAIMS FOR SUCH SERVICES PROVIDED SINCE JANUARY 1, 1976. HOWEVER, THE EFFECTIVE DATE OF SUCH CHANGE WILL VARY FROM POLICY TO POLICY.

IF ANY QUALIFIED PROVIDER RENDERED TREATMENT FOR A MENTAL OR NERVOUS CONDITION SINCE JANUARY 1, 1976, AND AFTER THE EFFECTIVE DATE OF SUCH CHANGE, AND FOR WHICH THE PROVIDER SUBMITTED A CLAIM WHICH WAS NOT ACCEPTED, THE CLAIM MAY BE RESUBMITTED. THE CLAIM WILL BE EXAMINED AND IF THE BENEFIT CHANGES DESCRIBED IN THIS NOTICE APPLY, THE CLAIM WILL BE PAID.

2. Commencing December 18, 1980, the defendants shall pay expenses for benefits required by G.L. c. 175, § 47B on claims submitted by subscribers for services rendered (1) after the effective date of the policy, in the case of policies issued since January 1, 1976, and (2) after the effective date of the change of coverage, in the case of policies issued prior to January 1, 1976.

DATED AT BOSTON, MASSACHUSETTS, THIS 25TH DAY OF NOVEMBER, 1980.

Form of Judgment Approved:

MICHAEL JOSEPH DONOVAN,
Clerk of Court

/s/ Peter F. Brady, J.
Associate Justice of the Superior Court

By /s/ Paul F. Mahoney
Assistant Clerk

APPENDIX I

COMMONWEALTH OF MASSACHUSETTS
SUPERIOR COURT

SUFFOLK, ss:

Civil Action No. 35598

COMMONWEALTH OF MASSACHUSETTS,
Plaintiff

v.

THE TRAVELERS INSURANCE COMPANY

and

METROPOLITAN LIFE INSURANCE COMPANY,
Defendants

MEMORANDUM OF DECISION

This action came on to be heard before this court pursuant to the plaintiff Commonwealth of Massachusetts' motion for preliminary injunctive relief.

A review of the materials submitted by all the parties reveals the following pertinent information: The defendants are two major insurance companies, Metropolitan Life Insurance Company and The Travelers Insurance Company. As one part of their businesses, these companies sell group insurance policies which include coverage for hospital and surgical expenses. The group policies under consideration here were executed and sold to policyholders[1] outside the Commonwealth, but the in-

[1] The policyholders include corporations and unions which have established employee benefit programs in accordance with the requirements of ERISA, the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et seq.

sured groups include individual subscribers who reside inside Massachusetts.

The Commonwealth urges that, since the groups include individual subscribers who reside in Massachusetts, the defendant insurers must provide, at least to the Massachusetts subscribers, coverage for expenses incurred for treatment of mental or nervous conditions, as required by G.L. c. 175, § 47B.[2] It is uncontested that the defendants do not provide these benefits, but they have suggested a number of reasons why they cannot be required to comply with G.L. c. 175, § 47B.

To compel compliance with this statute, the Commonwealth brought this action in which it seeks temporary and permanent injunctive relief, as well as a declaratory judgment. Only the Commonwealth's motion for a preliminary injunction is before this court at this time.

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[2] G.L. c. 175, § 47B provides, in relevant part, as follows:

> Any blanket or general policy of insurance described in subdivision (A), (C), or (D) of section one hundred and ten which provides hospital expense and surgical expense insurance and which is issued or subsequently renewed by agreement between the insurer and the policyholder, within or without the Commonwealth, . . . [shall] provide benefits for expense of residents of the Commonwealth covered under any such policy or plan, arising from mental or nervous conditions . . . which are at least equal to the following minimum requirement:
>
> . . . (c) In the case of outpatients benefits, these shall cover, to the extent of five hundred dollars over a twelve-month period, services furnished (1) by a comprehensive health service organization, (2) by a licensed or accredited hospital (3) or subject to the approval of the department of mental health services furnished by a community mental health center . . . which furnishes mental health services or (4) consultations or diagnostic or treatment sessions, provided that such services under this clause are rendered by a psychotherapist or by a psychologist licensed under provisions of chapter one hundred and twelve.

Whether this relief is sought under G.L. c. 175, § 3B[3] or under Mass. R. Civ. P. 65, the grant of such an order must be based upon findings both that the Commonwealth has demonstrated a strong likelihood of success on the merits of its claims that, if the requested injunction is not issued, irreparable harm will result to the Commonwealth outweighing any harm that defendants will suffer if the injunction is issued. *Lewis v. Richardson*, 428 F. Supp. 1164 (D. Mass. 1977); *Taunton Greyhound Association v. Town of Dighton*, Mass. Adv. Sh. (1977) 1521, 1526 n.3; *Thayer Co. v. Binnall*, 326 Mass. 467, 475 (1950). The Commonwealth has successfully made both showings in this action.

Probability of Success of the Merits

In its brief, the defendant insurance companies advance three major arguments in support of their contention that they cannot be forced to comply with G.L. c. 175, § 47B. First, they argue that ERISA preempts the application of § 47B to the policies involved in the action. Second, they argue that the NLRA[4] also preempts § 47B. Finally, the defendants argue that the extraterritorial enforcement of § 47B would violate the Commerce Clause of the Constitution of the United States. The Commonwealth will in all probability, prevail on each of these points, and, as such, is likely to succeed on the merits of its case.

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[3] That statute authorizes the attorney general to seek injunctions to prevent violations of c. 175. Such injunctions may be issued upon two showings: "that a defendant is threatening or is likely to do any act or acts in violation of this chapter, and that such violation will cause irreparable injury to the interests of the people of the Commonwealth. . . ." Presumably, to obtain a preliminary injunction pursuant to § 3B, the attorney general must show a probability of success on the merits (that a defendant is or may violate the chapter) as well as show some irreparable harm that will occur without preliminary relief.

[4] National Labor Relations Act, 29 U.S.C. § 141 *et seq.*

Application of § 47B to the group insurance policies involved in this action is not precluded by ERISA's preemption provisions. Determining the scope of ERISA preemption involves a three-pronged analysis. Congress opted for a broad, general preemption provision, 29 U.S.C., § 1144(a). That section provides as follows:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall *supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan* described in section 1003(a) and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

The insurance policies involved here are employee benefit plans within the meaning of 29 U.S.C. 1003(a), and are not within the exceptions contained in 29 U.S.C. § 1003 (b). Further, there is no question but that the Massachusetts statute, G.L. c. 175, § 47B relates to those plans. Thus, absent more, § 47B would be preempted by the broad language contained in § 1144(a).[5]

However, Congress did not stop with the broad preemption provision, and the second prong of analysis involves the "saving clause", § 1144(2)(A). That clause provides that:

> Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities.

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[5] For a discussion of the fact that Congress opted for broad ERISA preemption, see *Hewlett-Packard Company v. Barnes*, 425 F. Supp. 1294, 1298-1300 (N.D. Cal. 1977), *aff'd* 571 F.2d 502 (9th Cir.), *cert. denied*, 99 S. Ct. 108 (1978). Innumerable other cases could be cited in support of this proposition. That Congress opted for a broad preemption provision is, however, not contested in this action.

G.L. c. 175, § 47B is a "law of any State which regulates insurance", and, would appear to be saved by the saving clause.

Finally, the saving clause is itself narrowed in the ERISA statutory scheme by the so-called deemer clause, § 1144(b)(2)(B), which provides:

> Neither an employee benefit plan described in section 1003(a) of this title . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

Thus, as relevant to this case, a state may not deem an ERISA plan or trust established under such a plan to be an insurance company for the purpose of subjecting the plan or trust to state insurance law.

Read together, the three quoted provisions set out a scheme whereby a state may subject insurance companies that sell group policies to ERISA plans to state regulation, but may not so regulate ERISA plans that function as self-insurers. As such, the Commonwealth is likely to prevail on its contention that the group policies sold by the defendants that provide coverage for hospital and surgical expenses must include the coverage mandated by G.L. c. 175, § 47B, at least for the individual subscribers in the groups who reside in Massachusetts.

This same view was advanced by the First Circuit in *Wadsworth v. Whaland*, 562 F.2d 70 (1st Cir. 1977), wherein a New Hampshire insurance law was upheld against an ERISA preemption argument. The New Hampshire statute was very similar to G.L. c. 175, § 47B, in that it, too, required that certain mental health benefits be contained in group policies sold outside New

Hampshire, but which included individual subscribers residing in that state.

> Thus, the deemer provision prevents a state from subjecting a plan, as a business of insurance, to the state's general insurance laws or enacting special legislation regulating plants as a "unique variety of insurance", *Hewlett-Packard Co. v. Barnes*, 425 F. Supp. 1294, 1300 (N.D. Cal. 1977) However, on its face the deemer provision does not prohibit a state from indirectly affecting plans by regulating the contents of group insurance policies purchased by the plans.

Wadsworth v. Whaland, 562 F.2d at 77-78.

Defendants vigorously attack the rationale of the distinction, that is, the distinction between a state's power to regulate self-insuring plans and its power to regulate plans that operate through the purchase of insurance. See Hutchinson & Ifshin, *Federal Preemption of State Law Under the Employee Retirement Income Security Act of 1974*, 46 U. Chi. L. Rev. 23, 68-69 (1978). Defendants cite with approval the view of Messrs. Hutchinson & Ifshin that a more sensible reading of ERISA would permit a state to

> indirectly protect an insured employee benefit plan by regulating underwriting and reserve policies of the insurance carrier, even if such regulation affects the cost of the plan. On the other hand, a state should not be allowed to require that an ERISA plan provide a substantive benefit by enforcing an insurance regulation against the insurance carrier that provides the policy to the plan.

46 U. Chi. L. Rev. at 66-67. No support for this distinction is found in ERISA. Indeed, Congress reaffirmed the national policy embodied in the McCarran-Ferguson Act, 15 U.S.C. §§ 1011 et seq., favoring state regulation of the insurance industry, not only in ERISA's saving

clause, 29 U.S.C. § 1144(b)(2)(A), but also in § 1144(d). The latter section provides, with exceptions not relevant here as follows:

> Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States . . . or any rule or regulation issued under any such law.

See also *Wadsworth*, 562 F.2d at 78, n.41. Absent a clear indication of Congressional intent to so sharply limit a state's power to regulate the insurance industry, it is probable that the trial court will adhere to the plain language of ERISA, thereby adopting the reasoning of the *Wadsworth* Court. If Congress finds that the adverse effect of the distinction outweighs the benefits of state regulation, it can certainly modify the statutory scheme.

Defendants second preemption argument is that, since many of the plans were the product of collective bargaining agreements, the National Labor Relations Act, 29 U.S.C. § 141 et seq., prohibits Massachusetts from imposing substantive provisions on the agreements. In view of the scope of ERISA preemption, this argument is also likely to be rejected at the full hearing on the merits of this action.

The United States Supreme Court recently considered the scope of NLRA preemption in *Malone v. White Motor Corporation*, 435 U.S. 497 (1978). In upholding a Minnesota statute relating to pension funding against an NLRA preemption argument, the Court indicated that the key in such an inquiry is the intent of Congress, and that not all state legislation that relates to matters subject to compulsory bargaining under the NLRA is preempted.

> There is little doubt that under the federal statutes governing labor-management relations, an employer must bargain about wages, hours, and work-

> ing conditions and that pension benefits are proper subjects of compulsory bargaining. But there is nothing in the NLRA, including these sections on which appellee relies, which expressly forecloses all state regulatory power with respect to those issues, such as pension plans, that may be the subject of collective bargaining. If the Pension Act is preempted here, the congressional intent to do so must be *implied* from the relevant provisions of the labor statutes.

435 U.S. at 504-505. (emphasis in original). Thus, in *Malone*, the Court looked to the relevant provisions of labor law, especially the nonpreemption provisions in § 10 of the Welfare and Pension Plans Disclosure Act of 1958,[6] and reasoned that Minnesota was free to mandate certain pension funding, even though its statute directly contradicted a provision in a collective bargaining agreement.

The Welfare and Pension Plans Disclosure Act of 1974 was explicitly repealed by ERISA, 29 U.S.C. § 1031 (a) (1), and, in enacting ERISA Congress opted for broad preemption of state laws affecting ERISA plans. However, whether or not a particular state law, here G.L. c. 175, § 47B, has been preempted by ERISA, requires an inquiry into the intent of Congress. As discussed at great length earlier in this memorandum,[7] G.L. c. 175, § 47B, is not preempted by ERISA. Further, no other provision of federal law requires preemption of the Massachusetts statute, and the fact that the coverage of many of the plans was the subject of collective bargaining agreements, without more, is unlikely to convince the trial court that preemption is appropriate. See 435 U.S. at 504-505.

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[6] Originally codified at 29 U.S.C. § 301 *et seq.* ERISA did not become effective until after the relevant events in *Malone*, and, as such, the 1958 enactment was found by the Supreme Court to be controlling. 435 U.S. at 505-506, n.7.

[7] See pages 3-7.

Defendants next suggest that the Commerce Clause of the United States Constitution prohibits the Commonwealth from forcing them to comply with G.L. c. 175, § 47B. This argument is highly unlikely to persuade the trial court.

The McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015, provided the states with broad authority to regulate insurance free from Commerce Clause attacks. *Prudential Insurance Company v. Benjamin*, 328 U.S. 408, 429-433 (1946). The principal limitations on this power relate to due process considerations, *State Board of Insurance v. Todd Shipyards Corporation*, 370 U.S. 451, 453-456 (1962), and to situations in which Congress itself has enacted insurance legislation, 15 U.S.C. § 1012(b). The latter exception is inapplicable here in view of the preemption scheme embodied in ERISA. The former exception finds its roots in the legislative history of the McCarran-Ferguson Act. A good example is provided by the following language, quoted in the *State Board of Insurance* case, 370 U.S. at 455-456:

> "It is not the intention of Congress in the enactment of this legislation to clothe the States with any power to regulate or tax the business of insurance beyond that which they had been held to possess prior to the decision of the United States Supreme Court in the Southeastern Underwriters Association case. Briefly, your committee is of the opinion that we should provide for the continued regulation and taxation of insurance by the States, subject always, however, to the limitations set out in the controlling decisions of the United States Supreme Court, as, for instance, in Allgeyer v. Louisiana (165 U.S. 578 [, 17 S.Ct. 427, 41 L. Ed. 832]), St. Louis Cotton Compress Co. v. Arkansas (260 U.S. 346 [, 43 S.Ct. 125, 67 L.Ed. 297)], and Connecticut General [Life] Insurance Co. v. Johnson (303 U.S. 77, [, 58 S.Ct. 436, 82 L.Ed. 673)], which hold, inter alia, that a State does not have power to tax contracts of insur-

> ance or reinsurance entered into outside its jurisdiction by individuals or corporations resident or domiciled therein covering risks within the State or to regulate such transactions in any way." H.R. Rep. No. 143, 79th Cong., 1st Sess., p. 3 U.S. Code Cong. Service 1945, p. 670.

In the three cases cited, the companies involved were found to have had too few contracts with the regulating state to justify the state action.

> . . . The Allgeyer case held that Louisiana by reason of the Due Process Clause of the Fourteenth Amendment could not make it a misdemeanor to effect insurance on Louisiana risks with an insurance company not licensed to do business in Louisiana, where the insured through use of the mails contracted in New York for the policy. The St. Louis Cotton Compress case held invalid under the Due Process Clause an Arkansas tax on the premiums paid for a policy on Arkansas risks, made with an out-of-state company having no office or agents in Arkansas. The Connecticut General Life Insurance case held invalid under the Due Process Clause a California tax on premiums paid in Connecticut by one insurance company to another for reinsurance of life insurance policies written in California on California residents, even though both insurance companies were authorized to do business in California. The Court stated:
>
> > "All that appellant did in effecting the reinsurance was done without the state and for its transaction no privilege or license by California was needful. The tax cannot be sustained either as laid on property, business done, or transactions carried on within the state, or as a tax on a privilege granted by the state." 303 U.S., at 82, 58 S.Ct. at 439.

By contrast, however, the defendants are likely to be found to have sufficient contacts with the Commonwealth of Massachusetts to justify the limited regulation imposed upon them by G.L. c. 175, § 47B. The defendant companies have been licensed to conduct insurance business in the Commonwealth for over one hundred years.[8] Both companies do an active business in Massachusetts and derive substantial income therefrom. Affidavit of Donald L. Becker at page 3. The group policies involved in this action include individual subscribers who reside inside the Commonwealth and to whom and/or for whom payments are made in Massachusetts. These contacts are likely to be found to be sufficient to justify the Commonwealth's enforcement of G.L. c. 175, § 47B, at least with respect to coverage for individual subscribers residing in Massachusetts.

Irreparable Harm

To obtain the preliminary relief requested, the Commonwealth must show that, in addition to a probability of success on the merits, irreparable harm will result to the interests of the people of the Commonwealth if the requested relief is not forthcoming, outweighing any harm that defendants will suffer if the injunction is not issued. *Lewis v. Richardson*, 428 F. Supp. 1164 (D. Mass. 1977); *Taunton Greyhound Racing Association v. Town of Dighton*, Mass. Adv. Sh. (1977) 1525, 1526 n. 3; *Thayer Company v. Binnall*, 326 Mass. 467, 475 (1950).

In support of its contention that irreparable harm has resulted and will continue to result from the failure of the defendants to comply with G.L. c. 175, § 47B, the

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[8] Exhibits A and B to the Commonwealth's complaint indicate that the Travelers Insurance Company has been continually licensed to do business in the Commonwealth since July 23, 1864, (Exhibit A), and that Metropolitan Life Insurance Company has been so licensed since November 15, 1866, (Exhibit B). These exhibits may properly be considered by this court as evidence, G.L. c. 175 § 16.

Commonwealth alleges that "many residents of the Commonwealth have been deterred from obtaining treatment, or have been forced to discontinue treatment for mental and nervous conditions." Complaint ¶ 17.

Defendants vigorously assert that this alleged harm is too speculative to provide the foundation for a mandatory preliminary injunction. It is true that harm such as that suggested by the Commonwealth defies quantification. It does not follow, however, that the harm is not present or that it is not irreparable.

An individual's decision to seek help for mental or nervous disorders is undoubtedly a complex and multifaceted one. This court has no difficulty accepting the proposition, however, that the financial costs of such treatment is frequently an important factor in making this decision. This factor may either deter an individual from seeking or continuing help, or, it may convince one to curtail the amount of treatment sought. It is equally clear that the Commonwealth has a strong interest in the mental health of its citizens and that G.L. c. 175, § 47B, was enacted to alleviate the financial pressures associated with mental health care.

In support of its irreparable harm argument, the Commonwealth has offered the affidavit of Carolyn A. LaMarre, an employee of the Massachusetts Association for Mental Health (MAMH).[9] In her affidavit, Ms. LaMarre describes a survey of various mental health clinics conducted by her in the summer and fall of 1978. She concludes, in relevant part, in the following manner:

> 8. Clinics have responded to the failure of certain insurance companies to reimburse for the treatment in three different ways: (a) some clinics require

[9] Ms. LaMarre describes the organization, in part, as follows: "MAMH, formed in 1913, is a private non-profit citizens organization working for quality mental health care in Massachusetts." Affidavit of Carolyn A. LaMarre at p. 1.

> that clients with insurance coverage pay the full amount of the fee even though the company refuses to pay. . .; (b) some clinics put the client whose company refuses to pay on a sliding scale fee based on their ability to pay a portion of the total clinic for the clinical service; (c) some clinics totally absorb or write off the cost of service to clients whose companies refuse to pay.

Affidavit of Carolyn A. LaMarre at p. 3. At least with respect to category (a) and, to some extent, category (b), clients must make the choice between paying or limiting or eliminating treatment. Indeed some clients may not even have the financial luxury of making the choice, as they may be unable to pay the entire fee or the part the clinic requires them to pay based upon its sliding scale.

The mental health of its citizenry is of paramount concern to the Commonwealth. The response of the clinics to the actions of insurance companies such as defendants, further buttress this court's conclusion that this mental health is being and will continue to be impaired by the refusal of defendants to comply with G.L. c. 175, § 47B. This is irreparable harm, and is more than sufficient to support the issuance of a preliminary injunction at this time.

Balanced against this harm is the severe financial loss defendants suggest they will suffer if they are forced to comply with G.L. c. 175, § 47B, should it turn out later that the statute is unenforceable against them. Defendants correctly point out that this situation is compounded by the fact that the Commonwealth cannot be required to post a bond as a precondition to the issuance of the injunction. G.L. c. 175, § 3B. However, it is unlikely that defendants will prevail on the merits, and it is possible that at least some of those additional costs can be recovered in later premium adjustment.

The court has compared the harm to the interests of the people of the Commonwealth that will result if a preliminary injunction is not issued with the financial loss that defendants will suffer if a preliminary injunction is issued. The scales weigh heavily in favor of issuing an injunction. The mental health of the people of the Commonwealth is too important to place in jeopardy particularly since, in all probability, the Commonwealth will succeed on the merits of its claim.

For the reasons set forth in this memorandum, it is hereby ordered that a preliminary injunction issue requiring that the defendants comply with the provisions of G.L. c. 175, § 47B. Plaintiff will be given ten days in which to propose to this court the precise terms of that injunction.

Entered: August 13, 1979

/s/ Joseph S. Mitchell, Jr.
JOSEPH S. MITCHELL, JR.
Justice of the Superior Court

APPENDIX J

ERISA

29 U.S.C. § 1001(b):

"It is hereby declared to be the policy of this Act to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts."

29 U.S.C. § 1002:

"For the purposes of this subchapter:

"(1) The terms 'employees welfare benefit plan' and 'welfare plan' mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

* * *

"(3) The term 'employee benefit plan' or 'plan' means an employee welfare benefit plan or an em-

ployee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan."

29 U.S.C. § 1003(b)(3):

"(b) The provisions of this subchapter shall not apply to any employee benefit plan if—

* * *

"(3) such plan is maintained solely for the purpose of complying with applicable workmen's compensation laws or unemployment compensation or disability insurance laws . . . ."

29 U.S.C. § 1144:

"(a) Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

"(b)(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

"(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

"(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such plan, shall be deemed to be an insurance

company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

"(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section 1136 of this title.

"(4) Subsection (a) of this section shall not apply to any generally applicable criminal law of a State.

"(c) For purposes of this section:

"(1) The term 'State law' includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

"(2) The term 'State' includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

"(d) Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(b) of this title) or any rule or regulation issued under any such law."

Section 47B (Massachusetts G.L. c. § 175 47B):

"Any blanket or general policy of insurance described in subdivision (A), (C), or (D) of section one hundred and ten which provides hospital expense

and surgical expense insurance and which is issued or subsequently renewed by agreement between the insurer and the policyholder, within or without the commonwealth, during the period this provision is effective, or any policy of accident and sickness insurance as described in section one hundred and eight which provides hospital expense and surgical expense insurance and which is delivered or issued for delivery or subsequently renewed by agreement between the insurer and the policyholder in this commonwealth during the period that this provision is effective, or any employees' health and welfare fund which provides hospital expense and surgical expense benefits and which is promulgated or renewed to any person or group of persons in this commonwealth while this provision is effective shall, provide benefits for expense of residents of the commonwealth covered under any such policy or plan, arising from mental or nervous conditions as described in the standard nomenclature of the American Psychiatric Association which are at least equal to the following minimum requirements:

"(a) In the case of benefits based upon confinement as an inpatient in a mental hospital under the direction and supervision of the department of mental health, or in a private mental hospital licensed by the department of mental health, the period of confinement for which benefits shall be payable shall be at least sixty days in any calendar year.

"(b) In the case of benefits based upon confinement as an inpatient in a licensed or accredited general hospital, such benefits shall be no different than for any other illness.

"(c) In the case of outpatient benefits, these shall cover, to the extent of five hundred dollars over a twelve-month period, services furnished (1) by a comprehensive health service organization, (2) by a

licensed or accredited hospital (3) or subject to the approval of the department of mental health services furnished by a community mental health center or other mental health clinic or day care center which furnishes mental health services or (4) consultations or diagnostic or treatment sessions, provided that such services under this clause are rendered by a psychotherapist or by a psychologist licensed under the provisions of chapter one hundred and twelve. For purposes of this clause 'psychotherapist' shall mean a person fully licensed to practice medicine under the provisions of chapter one hundred and twelve, who devotes a substantial portion of his time to the practice of psychiatry."

NLRA

29 U.S.C. § 151. Findings and declaration of policy

The denial by some employers of the right of employees to organize and the refusal by some employers to accept the procedure of collective bargaining lead to strikes and other forms of industrial strife or unrest, which have the intent or the necessary effect of burdening or obstructing commerce by (a) impairing the efficiency, safety, or operation of the instrumentalities of commerce; (b) occurring in the current of commerce; (c) materially affecting, restraining, or controlling the flow of raw materials or manufactured or processed goods from or into the channels of commerce, or the prices of such materials or goods in commerce; or (d) causing diminution of employment and wages in such volume as substantially to impair or disrupt the market for goods flowing from or into the channels of commerce.

The inequality of bargaining power between employees who do not possess full freedom of association or actual liberty of contract, and employers who are organized in the corporate or other forms of

ownership association substantially burdens and affects the flow of commerce, and tends to aggravate recurrent business depressions, by depressing wage rates and the purchasing power of wage earners in industry and by preventing the stabilization of competitive wage rates and working conditions within and between industries.

Experience has proved that protection by law of the right of employees to organize and bargain collectively safeguards commerce from injury, impairment, or interruption, and promotes the flow of commerce by removing certain recognized sources of industrial strife and unrest, by encouraging practices fundamental to the friendly adjustment of industrial disputes arising out of differences as to wages, hours, or other working conditions, and by restoring equality of bargaining power between employers and employees.

Experience has further demonstrated that certain practices by some labor organizations, their officers, and members have the intent or the necessary effect of burdening or obstructing commerce by preventing the free flow of goods in such commerce through strikes and other forms of industrial unrest or through concerted activities which impair the interest of the public in the free flow of such commerce. The elimination of such practices is a necessary condition to the assurance of the rights herein guaranteed.

It is declared to be the policy of the United States to eliminate the causes of certain substantial obstructions to the free flow of commerce and to mitigate and eliminate these obstructions when they have occurred by encouraging the practice and procedure of collective bargaining and by protecting the exercise by workers of full freedom of association, self-organization, and designation of representatives of their own choosing, for the purpose of negotiating

the terms and conditions of their employment or other mutual aid or protection.

29 U.S.C. § 157. Right of employees as to organization, collective bargaining, etc.

Employees shall have the right to self-organization, to form, join, or assist labor organizations, to bargain collectively through representatives of their own choosing, and to engage in other concerted activities for the purpose of collective bargaining or other mutual aid or protection, and shall also have the right to refrain from any or all of such activities except to the extent that such right may be affected by an agreement requiring membership in a labor organization as a condition of employment as authorized in section 158(a)(3) of this title.

29 U.S.C. § 158. Unfair labor practices

* * *

(d) Obligation to bargain collectively

For the purposes of this section, to bargain collectively is the performance of the mutual obligation of the employer and the representative of the employees to meet at reasonable times and confer in good faith with respect to wages, hours, and other terms and conditions of employment, or the negotiation of an agreement, or any question arising thereunder, and the execution of a written contract incorporating any agreement if requested by either party, but such obligation does not compel either party to agree to a proposal or require the making of a concession.

* * *

McCARRAN-FERGUSON ACT

15 U.S.C. § 1012:

(3) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

(2) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided*, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State Law.

15 U.S.C. § 1014:

Nothing contained in this chapter shall be construed to affect in any manner the application to the business of insurance of the Act of July 5, 1935, as amended, known as the National Labor Relations Act, or the Act of June 25, 1938, as amended, known as the Fair Labor Standards Act of 1938, or the Act of June 5, 1920, known as the Merchant Marine Act, 1920.

APPENDIX K

IN THE SUPREME JUDICIAL COURT FOR THE COMMONWEALTH OF MASSACHUSETTS

No. 2542

COMMONWEALTH OF MASSACHUSETTS,
Plaintiff-Appellee

v.

THE TRAVELERS INSURANCE COMPANY, and METROPOLITAN LIFE INSURANCE COMPANY,
Defendants-Appellants

NOTICE OF APPEAL TO THE SUPREME COURT OF THE UNITED STATES

Notice is hereby given that The Travelers Insurance Company and Metropolitan Life Insurance Company, defendants-appellants in this case, appeal to the Supreme Court of the United States from the final judgment entered in this action on April 25, 1984.

This appeal is taken pursuant to 28 U.S.C. 1257(2) and 2101.

Respectfully submitted,

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Dated: May 29, 1984

Nos. 84-325 and 84-356

Office - Supreme Court, U.S.
FILED
SEP 7 1984
ALEXANDER L. STEVAS,
CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

METROPOLITAN LIFE INSURANCE COMPANY,
Appellant,

v.

COMMONWEALTH OF MASSACHUSETTS,
Appellee.

THE TRAVELERS INSURANCE COMPANY,
Appellant,

v.

COMMONWEALTH OF MASSACHUSETTS,
Appellee.

On Appeal From The Supreme Judicial Court For The Commonwealth Of Massachusetts

BRIEF *AMICUS CURIAE* OF THE ERISA INDUSTRY COMMITTEE IN SUPPORT OF APPELLANTS' JURISDICTIONAL STATEMENTS

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

Nos. 84-325 and 84-356

METROPOLITAN LIFE INSURANCE COMPANY,
Appellant,

v.

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THE TRAVELERS INSURANCE COMPANY,
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COMMONWEALTH OF MASSACHUSETTS,
Appellee.

On Appeal From The Supreme Judicial Court For The Commonwealth Of Massachusetts

---

BRIEF *AMICUS CURIAE* OF THE ERISA INDUSTRY COMMITTEE IN SUPPORT OF APPELLANTS' JURISDICTIONAL STATEMENTS

This case presents a question of fundamental importance to the Nation's employers and their employees—whether state legislatures are free, in the guise of "insurance regulation," to dictate the benefits that must be provided by insured employee benefit plans. The decision below holds that a Massachusetts statute requiring specific mental health benefits to be included

in all health insurance policies covering state residents—a statute whose express purpose and principal effect were to govern employee benefit plans—is not pre-empted by the Employee Retirement Income Security Act of 1974 ("ERISA") or the National Labor Relations Act ("NLRA"). This result threatens to force employers either to assume the great burden and expense of conforming their insured employee benefit plans to ever-changing laws of fifty different states, or to abandon insured employee benefit plans altogether.

The ERISA Industry Committee submits this *amicus curiae* brief, with the consent of the parties, to urge the Court to note jurisdiction of these two appeals and give plenary consideration to this important state-court decision.

THE INTEREST OF *AMICUS* AND THE GREAT PUBLIC SIGNIFICANCE OF THE ISSUES INVOLVED

The ERISA Industry Committee ("ERIC") is a nonprofit association of over one hundred major corporations doing business in a wide variety of American industries. A list of ERIC's members is set forth in the Appendix hereto. Through ERIC, member companies express their views to the courts, the Congress, and the Executive Branch on issues affecting private pension and welfare plans.

ERIC represents a broad cross-section of firms maintaining health benefit plans and other employee welfare plans. ("Welfare plans" are employee benefit plans that provide non-pension benefits, such as health, accident, or supplemental unemployment benefits.) ERIC members' welfare plans cover tens of millions of beneficiaries. All of the members of ERIC do business in more than one state, and a number have employees in all fifty states. Transfers of employees from one state to another are common. Many of the welfare plans of ERIC's members provide uniform benefits in all states where beneficiaries are located. Such nationwide benefit uniformity is important to employee morale and yields significant savings in administrative expenses.

Most of the welfare plans of ERIC's members are *insured plans*—that is, they provide benefits through the purchase of group insurance policies covering their beneficiaries. Under an insured plan, the employer pays a premium to the insurance company, and the insurance company generally assumes the risk as to the actual level of benefits that will be payable during the term of the policy.[1] Some ERIC members maintain *non-insured plans.* Under these plans, the cost of benefits is the direct responsibility of the employer, who is sometimes referred to as a "self-insurer." As a rule, "self-insurance" is an economically feasible alternative to purchasing insurance from an insurance company only where a plan is large enough to allow the risk to be spread over a large population. While self-insurance has been growing, insured welfare plans remain much more common. For example, among medium and large firms nationwide, insured health plans covered about four times as many individuals as self-insured plans in 1982. U.S. DEPARTMENT OF LABOR, BUREAU OF LABOR STATISTICS, EMPLOYEE BENEFITS IN MEDIUM AND LARGE FIRMS, 1982, at 36 (1983).

Whether state governments can dictate the benefits of insured welfare plans is a question of great importance to ERIC's members and their employees. The companies participating in ERIC spend hundreds of millions of dollars each year on insurance premiums and administrative expenses

[1] Some insurance policies, particularly for large plans, are "experience rated," which means that the premium is based on the actual claims experience under the policy. Generally, under such policies, if the plan has a surplus in a particular year (premiums exceed claims and expenses), the plan receives a refund or credit of some portion of the premiums, while if the plan incurs a deficit (claims and expenses exceed premiums), the employer can choose between not renewing the policy, in which case the insurance company absorbs the deficit, or renewing the policy and paying some or all of the deficit over a period of time. Under experience-rated policies of this kind, risks are not borne entirely by the insurance company, but rather are shared between the insurance company and the employer.

for insured welfare plans.[2] Laws increasing the costs of insured welfare plans can have a substantial economic impact on a business. Welfare-plan benefits are a major issue in collective bargaining negotiations and are a major factor in compensation decisions for non-union employees.

If the states are permitted to enforce a crazy quilt of mandatory-benefit laws against insured welfare plans, both employers and employees will suffer. Companies with insured plans will be forced either to adopt all-encompassing benefit packages that satisfy the laws of every state, which will greatly increase total benefit costs, or to provide a variety of different benefits on a state-by-state basis, which will impose costly administrative burdens and cause dissatisfaction and confusion among employees. Free give-and-take in collective bargaining, as well as employers' ability to offer their non-union employees attractive pay and benefit packages at acceptable cost, will be supplanted by state prescription of a key element of compensation. Employees will be forced to accept benefits they would not have chosen themselves, and to sacrifice benefits they would have preferred. The only other alternative for such employers will be to abandon their insured plans completely and shoulder the risks and costs of "self-insurance"—risks and costs they decided *not* to incur when they established insured plans. In sum, both employers and employees will be prevented from achieving the best possible benefits at the most reasonable cost.

The result will be that fundamental purposes of ERISA—national uniformity in benefit-plan regulation and the growth and soundness of employee benefit plans—will be frustrated. These grave consequences, as well as the importance of the legal questions presented, call for this Court's review of the decision below.

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[2] Nationally, health insurance premiums totalled $85 billion in 1981, most of which was paid by employers. HEALTH INSURANCE ASSOCIATION OF AMERICA, SOURCE BOOK OF HEALTH INSURANCE DATA, 1982-1983, at 6 (1982). Some three-fourths of the full-time employees of private firms are covered by health plans. U.S. DEPARTMENT OF LABOR, LABOR-MANAGEMENT SERVICES ADMINISTRATION, GROUP HEALTH INSURANCE COVERAGE OF PRIVATE FULL-TIME WAGE AND SALARY WORKERS, 1979, at 15 (1981).

THIS CASE PRESENTS SUBSTANTIAL FEDERAL QUESTIONS

Section 47B of Chapter 175 of the Massachusetts General Laws requires that insurance policies that provide hospital and surgical benefits for state residents also must provide specified mental health benefits.[3] Section 47B also requires that these same benefits be provided by "any employees' health and welfare fund which provides hospital expense and surgical expense benefits" in the state. Thus, the statute's clear purpose is to mandate health benefits for *all employee benefit plans,* both insured and non-insured. This is confirmed by the only legislative material available. The explanatory report of the joint committee that originated the bill makes clear that the committee's objective was to furnish mental health benefits for "workers." MASS. GEN. COURT, JT. COMM. ON INSURANCE, ADVANCES IN HEALTH INSURANCE IN MASSACHUSETTS 1, 3, 4 (1974).

A. ERISA Pre-Emption

In this action, the appellants argued that Section 47B was pre-empted by both ERISA and the NLRA. The ERISA pre-emption issue received the primary attention of the court below.

ERISA pre-empts all state laws insofar as they "relate to any employee benefit plan." ERISA § 514(a), 29 U.S.C. § 1144(a). Exempted from this pre-emption, however, is any state law "which regulates insurance." ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). This is often referred to as the "insurance savings clause." ERISA also provides that, in applying the insurance savings clause, an employee benefit plan shall not "be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts." ERISA § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B). This is often referred to as the "deemer clause."

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[3] These include payment for sixty days' hospitalization in a mental hospital, benefits for hospitalization in a general hospital for mental or nervous conditions that are equal to the benefits provided for other illnesses, and $500 per year for certain out-patient mental health benefits.

The question confronting the Massachusetts Supreme Judicial Court below was whether Section 47B is a law "which regulates insurance" within the meaning of ERISA's insurance savings clause—and thus exempt from pre-emption—or is preempted by ERISA's basic pre-emption provision, particularly as read together with the expression of Congressional intent in the deemer clause to prevent state insurance laws from being used as a pretext for state regulation of employee benefit plans.

The court began its analysis of this question by artificially bifurcating Section 47B. The state had conceded that insofar as the statute applied explicitly to non-insured employee benefit plans, it was pre-empted by ERISA. The court concluded that this aspect of the statute was severable as a matter of general state-law severability doctrine, and thus proceeded to review Section 47B as if it had been solely a law directed at insurance policies. *Attorney General* v. *Travelers Insurance Co.*, 385 Mass. 598, 601, 433 N.E.2d 1223, 1225, App. 13a, 15a-16a (1982), *vacated & remanded,* 103 S. Ct. 3563, App. 10a (1983), *on remand,* 391 Mass. 730, 463 N.E.2d 548, App. 1a (1984).

The court next recognized that a literal reading of the insurance savings clause, exempting any state law bearing the label "insurance" from pre-emption, was untenable, as this would give states virtually unlimited rein to govern employee benefit plans under the pretext of insurance regulation. As the court put it, this construction "might permit the State, through its insurance laws, to reach far into areas governed by ERISA, and thereby negate the unmistakable intent of Congress to work a broad preemption." *Id.* at 606, 433 N.E.2d at 1228, App. at 21a.

The court was thus faced with the task of drawing a line between non-pre-empted state insurance laws and those state laws that, while purporting on their face to involve insurance, *are* pre-empted. The court decided that the appropriate basis for distinction was whether the state statute was in "clear conflict" with affirmative regulatory provisions of ERISA. *Id.* Since ERISA's affirmative regulation of welfare plans is limited to reporting, disclosure, fiduciary conduct, and plan administration, and ERISA, in contrast to Section 47B, does not prescribe the "substantive content of plans," the court concluded that Section 47B was not pre-empted. The court rejected the idea that ERISA was also actuated by fundamental policies of encouraging private initiative in structuring healthy, growing, broad-based employee benefit plans and allowing plan sponsors to enjoy a climate conducive to nationwide plan uniformity without interference from conflicting state laws. Instead, the court thought it could discern in this Court's decision in *Alessi* v. *Raybestos-Manhattan, Inc.,* 451 U.S. 504 (1981), intimations that ERISA's pre-emption was aimed solely at state laws that "affected a subject covered by ERISA." 385 Mass. at 608, 433 N.E.2d at 1229, App. at 23a.

On appeal, 103 S. Ct. 3563, App. 10a (1983), this Court vacated and remanded for further consideration in light of *Shaw* v. *Delta Air Lines, Inc.,* 103 S. Ct. 2890 (1983). *Shaw,* which repeatedly stressed that the exceptions from pre-emption in ERISA are "narrow" (*id.* at 2902, 2903), undermined both the Massachusetts Supreme Judicial Court's conflict-based notion of ERISA pre-emption and the Massachusetts court's rejection of private initiative and uniformity as fundamental goals of ERISA.

Shaw held that ERISA pre-empted a New York antidiscrimination law and a New York law requiring that sick-leave benefits be paid to employees unable to work because of pregnancy. In so holding, the Court specifically noted that ERISA "does not mandate that employers provide any particular benefits, and does not itself proscribe discrimination in the provision of employee benefits"—thus clearly rejecting the notion of the Massachusetts court in this case that conflict is the necessary predicate for pre-emption. *Id.* at 2897.

Further, *Shaw* cited *Alessi* for the proposition that ERISA, in "establishing benefit plan regulation 'as exclusively a federal concern,'" was aimed at minimizing "the need for interstate employers to administer their plans differently in each State in

which they have employees." *Id.* at 2904 (quoting *Alessi*, 451 U.S. at 523). In words equally applicable here, *Shaw* pointed out that allowing "varied and perhaps conflicting" state laws to be enforced against employee benefit plans would undercut employers' freedom to administer efficient, uniform employee benefit plans and would leave employers with a series of unattractive options. Among these options would be setting up different plans in each state—with "the inefficiency of such a system presumably . . . paid for by lowering benefit levels"—and adopting uniform plans that met the requirements of all states—which would require the employer to "reduce wages or eliminate those benefits not required by any State" in order to "offset the additional expenses." *Id.* at 2904 n.25. These very same adverse consequences are the inevitable result of the Massachusetts court's decision in this case.

Despite the clear rejection in *Shaw* of the Massachusetts Supreme Judicial Court's earlier reasoning, the court refused on remand to alter its decision. *Shaw*'s repeated characterization of ERISA's pre-emption exceptions as "narrow" was dismissed as "dictum," and the Supreme Judicial Court instead insisted on its own view of the insurance savings clause as "broad." 391 Mass. at 733-35, 463 N.E.2d at 550-51, App. at 4a-6a. The court acknowledged that *Shaw* "rejected a conflict-based analysis" of ERISA's general pre-emption provision, but nonetheless reaffirmed its own conflict-based theory of ERISA's insurance savings clause. *Id.* at 734, 463 N.E.2d at 551, App. at 5a. Finally, the court, while conceding that it was required to "accept as authoritative" this Court's conclusion in *Shaw* that ERISA was intended to foster private initiative and uniformity in benefit plans, now treated these policies as irrelevant. *Id.* at 734, 463 N.E.2d at 551, App. at 6a. While the Massachusetts court's earlier decision had recognized that ERISA's insurance savings clause cannot be applied literally, and had sought to interpret it based on the court's views of the policies animating ERISA, now, faced with an authoritative Supreme Court decision rejecting its notions of Congress' intent, the court set aside intent and reaffirmed its prior decision on the basis of the "language" that it had previously recognized to be the beginning—not the end—of the analysis. *Id.* at 735, 463 N.E.2d at 551, App. at 6a.

The ERISA pre-emption issue presented in this case is a substantial federal question for the following reasons:

1. It is an important question of first impression. No prior decision of this Court interprets ERISA's insurance savings clause. The lower courts are divided on the matter,[4] as are the commentators.[5]

2. The treatment of the issue by the court below is unsatisfactory. In reaffirming its earlier decision, the Massachusetts Supreme Judicial Court evaded the many conflicts between that decision and this Court's holdings in *Shaw* and *Alessi*. Moreover, while the court recognized (at least in its first opinion) that the insurance savings clause could not be interpreted literally because this would turn it into a loophole that could consume ERISA's primary mandate of preemption—a conclusion that was clearly correct[6]—the "clear conflict" standard that the court

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[4] *Compare, e.g.*, Metropolitan Life Insurance Co. v. Whaland, 410 A.2d 635 (N.H. 1979) (state mandatory benefit law not pre-empted), *with, e.g.*, Michigan United Food & Commercial Workers Fund v. Baerwaldt, 572 F. Supp. 943 (E.D. Mich. 1983), *appeal docketed*, No. 83-1570 (6th Cir. Aug. 16, 1983) (state mandatory benefit law pre-empted).

[5] *Compare, e.g.*, Brummond, *Federal Preemption of State Insurance Laws Under ERISA*, 62 IOWA L. REV. 57, 115-21 (1976) (opposing pre-emption), *with, e.g.*, Hutchinson & Ifshin, *Federal Preemption of State Law Under the Employee Retirement Income Security Act of 1974*, 46 U. CHI. L. REV. 23, 68-69 (1978) (favoring pre-emption). *See also* Kilberg & Heron, *The Preemption of State Law Under ERISA*, 1979 DUKE L.J. 383, 402 (courts have "given little guidance in determining when a state law which is merely labeled as an 'insurance law' may be a guise to regulate employee benefit plans and when such a law is a legitimate exercise of the state's traditional authority in the area of insurance").

[6] The purpose of a statute, and not its literal words, must be followed where literalism would produce a result "plainly at variance with the policy of the legislation as a whole." United States v. American Trucking Ass'ns, Inc., 310 U.S. 534, 543 (1940) (quoting Ozawa v. United States, 260 U.S. 168, 194 (1922)). As the Massachusetts court recognized in its first decision, this would be the effect of a literal reading of ERISA's insurance savings clause. Such a construction would give states unlimited power to regulate insured employee benefit plans. ERISA specifically recognizes the particular importance of insured plans, in defining "employee welfare benefit plan" as a plan that provides benefits "through the purchase of insurance or otherwise." ERISA § 3(1), 29 U.S.C. § 1002(1).

advanced as an alternative is untenable. It allows basic policies behind ERISA—fostering uniformity in employee benefit plans and encouraging their growth and soundness through private initiative—to be defeated by statutes that are labelled "insurance regulation" but are actually aimed at governing employee benefit plans. As this Court said in *Alessi,* "ERISA's authors clearly meant to preclude the States from avoiding through form the substance of the pre-emption provision." 451 U.S. at 525.

This Court should assume jurisdiction of this case and adopt a construction of ERISA's insurance savings clause that preserves legitimate state insurance regulation without undermining Congress' overriding objective of freeing employee benefit plans from conflicting and intrusive state regulation. The proper conclusion is that Congress meant to leave traditional insurance regulation to the states—regulation, for example, of capitalization, the form of policies, fiduciary and investment standards, and sales practices—but *not* to leave the states free to adopt laws formally classified as insurance laws but with the primary effect of governing employee benefit plans. Construing the insurance savings clause in this way clearly requires pre-emption of the present statute—which was expressly aimed at employee benefit plans [7]—while leaving the states wide scope to enact insurance laws with secondary or incidental effects on employee benefit plans.

[7] ERISA's pre-emption provisions are directed at state laws that regulate "the terms and conditions of employee benefit plans." ERISA § 514(c)(2), 29 U.S.C. § 114(c)(2). This was exactly the intent and result of Section 47B. The Massachusetts Supreme Judicial Court's bifurcation of the statute disregarded this fact, and failed to come to grips with the federal-law question of statutory interpretation—independent of any state-law severability issue—of whether, in light of its purpose and effect, Section 47B could be considered a law "which regulates insurance" within the meaning of ERISA's insurance savings clause.

3. The court below ignored or misconstrued materials that illuminate Congress' intent. One source of guidance is the deemer clause, which the Massachusetts court dealt with only in passing, asserting without explanation that it reinforced the court's conclusion. 385 Mass. at 606, 433 N.E.2d at 1228, App. at 21a (deemer clause described as "one indication of the breadth of the savings clause"). Rather than supporting the decision below, the deemer clause demonstrates a Congressional concern that the insurance savings clause not become a pretext for state action evading ERISA's establishment of "benefit plan regulation 'as exclusively a federal concern' " (*Shaw,* 103 S. Ct. at 2904 (quoting *Alessi,* 451 U.S. at 523)).

Another source of guidance is the legislative history of ERISA. That history makes clear that ERISA's pre-emption provisions were adopted in order to preclude "multiple," "conflicting," and "inconsistent" state laws regulating employee benefit plans—not just, as the court below thought, in areas affirmatively regulated by ERISA, but in *all* areas. *See* 120 CONG. REC. 29197, 29933, 29942 (1974) (remarks of Rep. Dent, Sen. Williams, and Sen. Javits) (quoted in *Shaw,* 103 S. Ct. at 2901 & n.20).[8]

B. NLRA Pre-Emption

Many insured welfare plans are collectively bargained. Section 47B undeniably intrudes on the freedom of labor and management to negotiate the terms of employment contracts. The impact is significant. Health benefits, for example, are a principal issue in labor negotiations. State-mandated benefits of one kind force workers to sacrifice other, preferred benefits of a different kind.

[8] *See also* H.R. REP. No. 1785, 94th Cong., 2d Sess. 47 (1977) (report of oversight hearings on ERISA pre-emption, declaring that "the Federal interest and the need for uniformity are so great that enforcement of state regulation should be precluded," and suggesting that this policy is threatened by unduly broad constructions of "our efforts to ensure minimum disruption to the regulatory efforts of the states in the fields of insurance, banking and securities"). The committee's reference to "*minimum*" disruption of state regulation is significant. It clearly implies that a literal reading of the insurance savings clause—which would permit *no* disruption of state insurance regulation—was not intended.

In *Local 24, International Brotherhood of Teamsters* v. *Oliver*, 358 U.S. 283 (1959), this Court held that the NLRA pre-empts state laws that prescribe terms of collectively-bargained labor agreements. Health benefits are a mandatory subject of bargaining. *Allied Chemical & Alkali Workers* v. *Pittsburgh Plate Glass Co.*, 404 U.S. 157, 159 (1971). Thus, *Oliver* would seem to be square authority that the NLRA pre-empts Section 47B as applied to collectively-bargained insured plans.

This conclusion is supported by the Court's decision in *Alessi, supra*. There, in holding that ERISA pre-empted state laws prohibiting workers' compensation benefits from being offset against pensions, the Court found its conclusion reinforced, insofar as collectively-bargained pension plans were concerned, by "the additional federal interest in precluding state interference with labor-management negotiations." 451 U.S. at 525 (citing *Oliver*). Pre-emption was compelled, the Court held, by the "direct clash between the state statute and the federal policy to keep calculation of pension benefits a subject of either labor-management negotiations or federal legislation." *Id.* at 526 n.22.

The Massachusetts Supreme Judicial Court nonetheless found that Section 47B was not pre-empted by the NLRA, on two grounds. First, the court found that there was a "public health" exception to NLRA pre-emption. The court reached this conclusion based on a remark in *Oliver* (358 U.S. at 297) that the state law pre-empted in that case was not a "local health or safety regulation." 385 Mass. at 613, 433 N.E.2d at 1232, App. at 29a-30a. Second, the court concluded that there is no NLRA pre-emption where some other federal statute expresses a Congressional intent to permit state regulation. The court found such an intent in Section 2(b) of the McCarran-Ferguson Act, 15 U.S.C. § 1012(b), which provides that federal statutes should not be construed as superseding state laws enacted "for the purpose of regulating the business of insurance." 385 Mass. at 613-14, 433 N.E.2d at 1232, App. at 30a.

This holding, like the lower court's ERISA pre-emption holding, presents a substantial question of federal law. This Court has had little occasion to apply the doctrine of *Oliver* that

state laws directly dictating the *substance* of labor-management agreements are pre-empted by the NLRA.[9] Rather, most of this Court's NLRA pre-emption decisions have focused on pre-emption of state laws affecting the *process* of labor-management relations. *See, e.g., San Diego Building Trades Council* v. *Garmon*, 359 U.S. 236 (1959); *Lodge 76, International Association of Machinists* v. *Wisconsin Employment Relations Commission*, 427 U.S. 132 (1976). The Court has never decided whether there is in fact a "public health" exception to the *Oliver* doctrine, much less defined its scope. Lower courts are divided on the issue. *See, e.g.*, Hutchinson & Ifshin, *supra* note 5, at 75.

Nor has this Court ever addressed whether the McCarran-Ferguson Act, which was enacted long before state legislatures first attempted to prescribe substantive terms of collective bargaining agreements through the vehicle of insurance laws, expresses a Congressional intent to permit such state legislation. The recent decision in *Malone* v. *White Motor Corp.*, 435 U.S. 497, 513 (1978) (plurality opinion), indicates that any such intent must be "evident" [10]—a test that the court below did not apply, and one it seems unlikely the McCarran-Ferguson Act could pass. Moreover, it is not clear that a statute enacted with the express purpose of regulating employee benefit plans subject to ERISA is properly regarded as a statute "regulating the business of insurance" within the meaning of the McCarran-Ferguson Act.[11] Finally, the Massachusetts court's summary dismissal in a footnote (385 Mass. at 614 n.25, 433 N.E.2d at 1232 n.25, App. at 30a n.25) of Section 4 of the McCarran-Ferguson Act, 15 U.S.C. § 1014—which provides that the

[9] The continuing validity of the doctrine was recognized, however, in Malone v. White Motor Corp., 435 U.S. 497, 512-14 (1978) (plurality opinion), and, as noted above, in *Alessi*.

[10] *See also* New York Telephone Co. v. New York State Department of Labor, 440 U.S. 519, 540-45 (1979) (plurality opinion); *id.* at 546 n.* (Brennan, J., concurring); *id.* at 547, 551 (Blackmun, J., concurring).

[11] *Cf.* Group Life & Health Insurance Co. v. Royal Drug Co., 440 U.S. 205 (1979) (Blue Shield Pharmacy Agreements are not exempt from antitrust laws as "the business of insurance" under the McCarran-Ferguson Act, particularly in light of the principle that exemptions from the antitrust laws are to be narrowly construed).

McCarran-Ferguson Act shall not affect "application [of the NLRA] to the business of insurance"—does not reflect the sort of careful analysis called for by the important issue of labor-law pre-emption posed by these cases.

CONCLUSION

The Court should note probable jurisdiction in these cases.

Respectfully submitted,

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APPENDIX

MEMBERS OF THE ERISA INDUSTRY COMMITTEE

Aetna Life and Casualty Company

Alexander & Alexander Services, Inc.

Allied Corporation

Aluminum Company of America

AMAX Inc.

American Telephone & Telegraph Company

Apache Corporation

ASARCO Incorporated

Atlantic Richfield Company

Bankers Trust Company

Bank of America N.T. & S.A.

Bell Communications Research

Bethlehem Steel Corporation

The Boeing Company

Bristol-Myers Company

Buck Consultants, Inc.

Caterpillar Tractor Co.

Champion International Corporation

The Chase Manhattan Bank, N.A.

Citibank, N.A.

The Coca-Cola Company

Columbia Gas System Service Corp.

Combustion Engineering, Inc.

Connecticut General Life Insurance Co.

Consolidated Foods Corporation

The Continental Group, Inc.

Coopers & Lybrand

Dart & Kraft Inc.

Deere & Company

Delta Air Lines Inc.

Digital Equipment Corp.

R. R. Donnelley & Sons Company

The Dow Chemical Company

Dresser Industries, Inc.

E. I. du Pont de Nemours & Company, Incorporated

Eastman Kodak Company

Eli Lilly and Company

Equitable Life Assurance Society of the United States

Esmark, Inc.

Exxon Corporation

Federated Department Stores, Inc.

FMC Corporation

Ford Motor Company

General Electric Company

General Mills, Inc.

General Motors Corporation

W. R. Grace & Co.

The Greyhound Corporation

Grumman Corporation

GTE Corporation

Gulf & Western Industries, Inc.

Frank B. Hall Consulting Company

John Hancock Mutual Life Insurance Co.

A. S. Hansen, Inc.

Hazlehurst & Associates, Inc.

H. J. Heinz Company

Hewitt Associates

Honeywell Inc.

ICI Americas, Inc.

Ingersoll-Rand Company

International Business Machines Corporation

International Harvester Company

International Telephone & Telegraph Corporation

Internorth, Inc.

Johnson & Johnson

Knight-Ridder Newspapers, Inc.

LTV Corp.

Manufacturers Hanover Trust Company

William M. Mercer, Inc.

Metropolitan Life Insurance Company

Minnesota Mining & Manufacturing Co.

Mobil Oil Corporation

Monsanto Company

Mutual of America

Occidental Petroleum Services, Inc.

Olin Corporation

Owens-Corning Fiberglas Corporation

Owens-Illinois, Inc.

J. C. Penney Company, Inc.

Pennzoil Company

PPG Industries, Inc.

Procter & Gamble Company

The Prudential Insurance Company of America

Ralston Purina Company

RCA Corporation

Republic Steel Corporation

R. J. Reynolds Industries, Inc.

Rockwell International Corporation

Sears, Roebuck and Co.

Shell Oil Company

The Southland Corporation

Sperry Corporation

Standard Oil Company of California

Standard Oil Company of Indiana

Standard Oil Company of Ohio

Sun Company, Inc.

Tampa Electric Company

Tenneco Inc.

Texaco Inc.

Textron Inc.

Time Incorporated

Towers, Perrin, Forster & Crosby Inc.

The Travelers Insurance Company

TRW Inc.

Union Camp Corporation

Union Carbide Corporation

United States Steel Corporation

United States Tobacco Company

United Technologies Corporation

Unocal Corporation

Westinghouse Electric Corporation

The Wyatt Company

Xerox Corporation

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Nos. 84-325 and 84-356

IN THE

Supreme Court of the United States

OCTOBER TERM, 1983

METROPOLITAN LIFE INSURANCE COMPANY,
Appellant

v.

COMMONWEALTH OF MASSACHUSETTS

THE TRAVELERS INSURANCE COMPANY,
Appellant

v.

COMMONWEALTH OF MASSACHUSETTS

ON APPEALS FROM THE SUPREME JUDICIAL COURT FOR THE COMMONWEALTH OF MASSACHUSETTS

BRIEF AMICUS CURIAE OF HEALTH INSURANCE ASSOCIATION OF AMERICA IN SUPPORT OF JURISDICTIONAL STATEMENTS

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ON APPEALS FROM THE SUPREME JUDICIAL COURT FOR THE COMMONWEALTH OF MASSACHUSETTS

BRIEF AMICUS CURIAE OF HEALTH INSURANCE ASSOCIATION OF AMERICA IN SUPPORT OF JURISDICTIONAL STATEMENTS

INTEREST OF AMICUS CURIAE

Health Insurance Association of America ("HIAA"), a Delaware nonprofit corporation, is an association of 327 private insurance companies, including the Appellants, Metropolitan Life Insurance Company and The Travelers Insurance Company. HIAA's member companies write over 85% of the health insurance policies written by private insurance companies in the United States and provide health insurance coverage to approximately 108

million people in the United States. See Source Book of Health Insurance Data 1982-83 at 13-20, Health Insurance Association of America. Approximately 85% of these people are covered under group health insurance policies, a substantial majority of which provide health insurance coverage to employee benefit plans that are regulated by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq.*

HIAA and its member companies are vitally interested in these appeals because they will resolve an issue that has perplexed the health insurance industry since the enactment of ERISA — namely, whether state mandated health benefit laws are enforceable against plans governed by ERISA.

A mandated health benefit law is one that requires a health insurance policy to provide coverage for a particular health care service. For example, Section 47B of Massachusetts General Laws Chapter 175 ("Section 47B") requires that all health insurance policies provide certain minimum benefits to Massachusetts residents for expenses arising from the treatment of mental or nervous conditions.[1] Mandated health benefit laws, like Section 47B, are

[1] Mandated health benefit laws, such as Section 47B, are the most obtrusive of a variety of state laws that attempt to affect the health benefits provided by employee benefit plans. Mandated health benefit laws, like Section 47B require that a policy include certain benefits, so that if the plan elects to purchase any coverage, it must purchase the mandated coverage. Another kind of state law requires that the insurance company make available certain benefits to anyone who wishes the coverage, but does not require that the coverage be purchased. Some state laws, like Section 47B, require that certain types of treatment be covered irrespective of the provider whose services are utilized. Others require that the services of certain classes of providers be covered — for example, the services of podiatrists or chiropractors or social workers. Some, like Section 47B, apply to all forms of health insurance policies. Others apply only to group or only to individual health insurance policies. Some apply only to policies that provide reimbursement for expenses actually incurred while others apply as well to those policies that pay fixed sums of money regardless of the actual treatment expenses incurred. Some, like Section 47B, are applicable to all residents of the enacting state. Others are limited to policies issued or delivered in the enacting state. The Appendices to this Brief attempt to provide a generalized state-by-state summary of these laws, together with an indication of the category into which each law falls along the continuum of state laws that attempt to affect the health benefits provided by employee benefit plans.

intended to dictate the benefits to be included in group health insurance policies and, therefore, are intended to have a direct impact on plans governed by ERISA.

As stated in greater detail below, HIAA and its member companies have consistently opposed the enactment of state mandated health benefit laws on the grounds that these laws restrict design flexibility, inhibit uniformity in benefit packages, increase costs to employers and employees and promote self-funding of benefit plans.

The importance of these appeals to HIAA and its member companies goes far beyond the particular state law in question; for these appeals may well determine the validity not only of Section 47B, but of other state mandated health benefit laws that are intended to apply to group health insurance policies issued to plans governed by ERISA.

Because much private health insurance is sold to employee benefit plans governed by ERISA, because state mandated health benefit laws undermine the ability of insurance companies and employee benefit plans to provide plan members needed coverage at a reasonable cost and because this Court's decision will have far-reaching effects, these appeals are of substantial interest and importance to HIAA and its member companies.

For the reasons stated below, HIAA and its member companies submit that the Supreme Judicial Court for the Commonwealth of Massachusetts was wrong in holding that Section 47B is not preempted by ERISA. Accordingly, HIAA, as the national trade association of the private health insurance industry, files this Brief Amicus Curiae in Support of the Jurisdictional Statements filed by the Appellants. Consent to the filing of this Brief has been obtained from counsel for the Appellants and the Appellee.

SUMMARY OF ARGUMENT

This Court has never addressed the question of whether ERISA preempts a state mandated health benefit law that is intended to apply to group health insurance policies issued to employee benefit plans governed by ERISA. These appeals pose this question in the context of the enforceability of Section 47B against employee benefit plans insured by policies issued by the Appellants.

It is undisputed that a state mandated health benefit law, such as Section 47B, which is intended to dictate particular benefits provided by an employee benefit plan *relates* to an employee benefit plan and, therefore, comes within the scope of Section 514(a) of ERISA, 29 U.S.C. § 1144(a), which preempts any state law insofar as it relates to an employee benefit plan governed by ERISA. The issue posed by these appeals is whether Section 47B is *saved* from preemption by Section 514(b)(2)(A) of ERISA, 29 U.S.C. § 1144(b)(2)(A), because it accomplishes its purpose through the plan's health insurance policy.

HIAA submits that Section 47B, like other state mandated health benefit laws, is not intended to regulate insurance. A state mandated health benefit law is intended to promote the utilization of particular health care services and is enacted, not for the protection of the insureds, but for the benefit of the consumer and provider

of those health care services for which coverage is required. This Court's most recent decisions on the breadth of the ERISA preemption and the narrowness of the exceptions to that preemption dictate the conclusion that a state mandated health benefit law is not a law that regulates insurance within the meaning of Section 514(b)(2)(A) of ERISA, 29 U.S.C. § 1144(b)(2)(A) and, therefore, may not be enforced against an employee benefit plan governed by ERISA.

ARGUMENT

HIAA asks the Court to note probable jurisdiction in order to reverse the decision below.

1.

Twenty-six states have enacted mandated health benefit laws, covering a wide range of health care services. Half of these have enacted laws, similar to Section 47B, requiring health insurance coverage for the treatment of mental and nervous disorders. One reason for the widespread appearance of state mandated health benefit laws for the treatment of mental and nervous disorders has been the devoted pursuit of this objective by organizations of mental health care providers, most notably psychiatrists, psychologists, psychotherapists and social workers.

The purpose of state mandated health benefit laws is to make the services of particular health care providers more accessible to the consumers of these services by shifting the payment obligation away from the consumer to a third party, typically the employer.[2] This increases the util-

[2] Even though the insurance policy provides the benefits and the insurance company either pays the provider or reimburses the consumer, it is the employer that typically bears the payment obligation through the payment of insurance premiums. Premiums for most group coverage are based on prior claims experience. Therefore, what is paid by the insurance company in claims is ultimately paid by the employer in premiums.

ization of the health care services for which benefits are mandated and virtually guarantees that the provider of the services will be paid a reasonable fee for services rendered. It is little wonder that in state after state health care providers have been the principal, and in many instances the only, advocates of mandated health benefit laws.

HIAA and its member companies have consistently opposed the enactment of mandated health benefit laws for the following reasons:[3]

1. *State mandated health benefit laws erode the ability of insurance companies to tailor health benefit packages to meet the needs of particular employee benefit plans and to market group health insurance policies to large employee benefit plans on a national basis.* A cost-effective package of health benefits requires both *flexibility* and *uniformity* — that is, flexibility to design a program that meets the objectives of the plan and uniformity that permits each employee, regardless of the state in which he works or lives, to receive the same benefits and to bear the same costs for these benefits as other members of the plan. State mandated health benefit laws frustrate these design requirements. As a result of state mandated health benefit laws, employers and unions are forced to purchase coverages that they neither want nor need. Not only does this unnecessarily increase the cost of insurance for employee benefit plans, it also reduces the number of dollars available to these plans for other, more desired benefits. Moreover, if a mandated health benefit law is

[3] See, generally, Robert E. Younger, "Mandated Insurance Coverage — the Achilles Heel of State Regulation?" XXIV Association of Life Insurance Counsel Proceedings 765-82 (1978); Arnold E. Buchman, "Extraterritorial Application of State Mandated Group Health Benefits" 15 The Forum 880-88 (1980), for a discussion of the detrimental effects of state mandated health benefit laws on group health insurance.

drafted so that it applies to all residents of the state regardless of whether the group policy itself was issued or delivered in the state,[4] uniformity of benefits is impossible, for the benefits provided by the group policy must conform not only to the statutory requirements of the state in which the policy was issued and delivered but also, with respect to any insured living in the state which enacted the mandated health benefit law, to the requirements of that law. This not only introduces administrative complexity, which increases the cost of providing health insurance to the plan, but also results in inequities among plan members inasmuch as some members receive greater benefits than others simply by reason of the state in which they live.

2. *State mandated health benefit laws are a major contributor to the rapidly escalating cost of health insurance for employee benefit plans.* Conservative estimates place the cost of mandated benefits at approximately 10% of the policy premium. Others in the industry believe that a more realistic estimate would place the cost of mandated benefits closer to 20% of the policy premium. Mandated health benefit laws contribute to increased costs for several reasons. First, the policy becomes more complicated and, therefore, more costly to administer. These administrative costs are "dead dollars" in that they do not result in increased policy benefits. Second, the policy becomes more expensive because it carries coverages that

[4] Such laws are generically referred to as "extraterritorial". Because group insurance policies are traditionally governed by the laws of the jurisdiction in which they are issued and delivered rather than the laws of the jurisdiction in which each insured lives or works, *Boseman v. Connecticut General Life Insurance Co.*, 301 U.S. 196 (1937), state laws are said to have extraterritorial application when they are intended to affect policies issued and delivered in other jurisdictions. Because Section 47B applies to all group policies, regardless of the state of issuance and delivery, to the extent such policies insure Massachusetts residents, Section 47B is extraterritorial.

the plan was forced by law to purchase. Third, the policy becomes more expensive because the underlying health care costs increase as a result of increased, but often unnecessary, utilization of the services for which coverage is mandated.

3. *State mandated health benefit laws promote self-insurance.* Coverages that are required by state law but unwanted by the insurance purchaser increase the likelihood that a purchaser will choose to buy *no* health insurance at all rather than bear the cost of unwanted coverages. Employers and unions have done precisely this in order to avoid the impact of state mandated health benefit laws. Rather than purchasing insurance for their employee benefit plans, many employers and unions have elected to fund the benefits themselves. Ironically, ERISA has promoted this trend toward self-funding because states have not been permitted by federal law to require *uninsured* employee benefit plans to provide particular health benefits.[5] When an employer or union chooses *not*

[5] The deemer clause of Section 514(b)(2)(B) of ERISA, 29 U.S.C. § 1144(b)(2)(B) prohibits states from using the savings clause of Section 514(b)(2)(A) of ERISA, 29 U.S.C. § 1144(b)(2)(A), to regulate employee benefit plans by treating such plans as insurers, banks, trust companies or investment companies. Courts have consistently interpreted and applied the deemer clause to prohibit state regulation of uninsured plans. *Dawson v. Whaland,* 529 F. Supp. 626 (D. N.H. 1982); *General Split Corporation v. Mitchell,* 523 F. Supp. 427 (E.D. Wisc. 1981); *St. Paul Electrical Workers Welfare Fund v. Markman,* 490 F. Supp. 931 (D. Minn. 1980); *Hewlett-Packard Company v. Barnes,* 425 F. Supp. 1294 (N.D. Cal. 1977); *aff'd per curiam,* 571 F.2d 502 (9th Cir. 1978). Indeed, one of the major ironies of this case is that if state mandated health benefit laws were to be held to be preserved by the savings clause of Section 514(b)(2)(A) of ERISA, 29 U.S.C. § 1144(b)(2)(A) with respect to *insured* plans, employers and unions would be encouraged to reject insurance and to provide uninsured plans to employees and union members, thereby freeing themselves from mandated health benefit laws by means of the deemer clause of Section 514(b)(2)(B) of ERISA, 29 U.S.C. § 1144(b)(2)(B). Because the

to purchase health insurance for its employee benefit plans, employees and union members suffer because uninsured health benefits are inherently less secure. State insurance laws and regulations protect against insurance company insolvency. No similar protections are available to assure that the assets of an uninsured plan will be sufficient to pay benefits to plan members.

Moreover, because of the self-funding option, mandated health benefit laws tend to create an artificial distinction between large and small employee benefit plans, a distinction never intended or contemplated by Congress. Large plans are likely to have the financial resources to self-fund and to avoid compliance with the state mandated health benefit laws. Small plans, by contrast, are likely to be compelled by their smaller financial resources either to purchase insurance and submit to state mandated health benefit laws or to join uninsured multiple employer trusts which, as a class, have been plagued historically by financial instability.

HIAA submits that, as a matter of sound public policy, employers and unions should *not* be forced to choose between submitting to costly and restrictive state mandated health benefit laws or leaving the health benefits of their employee benefit plans uninsured. HIAA further submits that this sound public policy is reflected in ERISA and that, as a matter of *federal law,* employee benefit plans may *not* be required by state law to provide mandated health benefits, irrespective of whether these plans are insured or uninsured.

benefits of an uninsured plan are less secure than those of an insured plan, this result is in conflict with the stated purpose of ERISA "to protect . . . the interests of participants in employee benefits plans and their beneficiaries. . . ." 29 U.S.C. § 1001.

2.

In enacting ERISA, Congress did *not* intend to save from preemption state laws, such as Section 47B, which require *insured* employee benefit plans to provide certain health benefits.

This Court has previously held that ERISA's preemption of state law is to be construed broadly and that the specific exceptions to that preemption are to be construed narrowly, *Shaw v. Delta Air Lines, Inc.*, 103 S. Ct. 2890 (1983); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981). However, this Court has not before had the opportunity to construe or apply the exception in Section 514(b)(2)(A) of ERISA, 29 U.S.C. § 1144(b)(2)(A), which saves from preemption "any law of any State which regulates insurance. . . ."

A number of appellate courts have addressed the relationship of a state mandated health benefit law and ERISA. *Attorney General v. The Travelers Insurance Company*, 391 Mass. 730, 463 N.E.2d 548 (1984); *Insurance Commissioner v. Metropolitan Life Insurance Company*, 296 Md. 334, 463 A.2d 793 (1983); *Wadsworth v. Whaland*, 562 F.2d 70 (1st Cir. 1977). Not one, however, has engaged in a serious analysis of whether a state mandated health benefit law is one that regulates insurance within the meaning of Section 514(b)(2)(A) of ERISA, 29 U.S.C. § 1144(b)(2)(A).[6]

[6] Not coincidentally, the one appellate court that did engage in such an analysis concluded that the state mandated health benefit law in question did *not* regulate insurance within the meaning of Section 514(b)(2)(A) of ERISA, 29 U.S.C. § 1144(b)(2)(A), and held the state law unenforceable against a group health insurance policy issued to an employee benefit plan governed by ERISA. *Metropolitan Life Insurance Company v. Insurance Commissioner*, 51 Md. App. 122, 441 A.2d 1098 (1982), *rev'd* 296 Md. 334, 463 A.2d 793 (1983).

The question posed by these appeals is far more complex than a reading of the opinions cited above might lead one to believe. It is not enough simply to assume, as these courts have, that, because a mandated health benefit law is found in the state insurance code, it is a law that regulates insurance.[7] The issue posed by the instant appeals is not whether a state mandated health benefit law *affects* insurance policies but whether it is a law that *regulates* insurance within the meaning of Section 514(b)(2)(A) of ERISA, 29 U.S.C. § 1144(b)(2)(A). This is an issue of *federal law* that is simply too important to be left to state courts that are not constitutionally empowered to resolve it in an authoritative manner. Because this issue affects scores of state laws throughout the nation and potentially every employee benefit plan governed by ERISA, it demands a final and definitive resolution by this Court.

3.

Other than emphasizing the narrowness of the exceptions to the sweeping preemption of Section 514(a) of ERISA, 29 U.S.C. § 1144(a), the legislative history of ERISA does not indicate Congress' view on what types of state laws it deemed to regulate insurance. Logically, one may presume that Congress was concerned with not casting the net of preemption over legitimate, traditional state insurance regulation which might incidentally interact with employee benefit plans but not have a substantive effect on the plans, directly or indirectly.

[7] See, *e.g.*, *Stone & Webster Engineering Corporation v. Ilsley*, 518 F. Supp. 1297, 1299 n.2 (D. Conn. 1981), aff'd 690 F.2d 323 (2nd Cir. 1982) in which the court held that a state law requiring employer contributions to an employee fund providing life and health insurance benefits was not a law regulating insurance but rather a law aimed at *employers* and, as such, was preempted by ERISA.

Mandated health benefit laws clearly do not fall within the scope of traditional state insurance regulation and clearly do have a direct substantive effect on employee benefit plans.

The primary and traditional purpose of state insurance regulation is to protect the *insured* from the *insurer* in matters dealing with the cost and reliability of coverage (including the solvency of insurance companies) and the fairness of underwriting decisions and marketing practices. As the U.S. District Court for the District of Kansas, in distinguishing an employee benefit plan preempted from state regulation by ERISA from a non-ERISA plan subject to state regulation, stated, the traditional purposes of insurance regulation are:

> "first to avoid overreaching by insurers; second, to assure solidity and solvency of insurers; third, to assure that rating classifications and rates are reasonable and fair."

Bell v. Employee Security Benefit Association, 437 F. Supp. 382, 391 (D. Kan. 1977), quoting with approval from Note, *Insurance Regulation — Employee Benefit Plans,* 28 Ark. L. Rev. 515, 517-18 (1975). Mandated health benefit laws do not address any of these traditional concerns of insurance regulation, but instead address concerns of health-care utilization and reimbursement. Consequently, such laws do not regulate insurance within the meaning of Section 514(b)(2)(A) of ERISA, 29 U.S.C. § 1144(b)(2)(A).

Whatever Massachusetts' interest may be in mandating health benefits to protect the interests of health-care providers and consumers, it may not elevate this state interest above *federal* regulation of employee benefit plans unless it can establish that this interest falls within one of the narrow exceptions to the preemption of Section 514(a) of ERISA, 29 U.S.C. § 1144(a). This it has not done, and given the nature of Section 47B, this it cannot do.

To the extent that Section 47B relates to the benefits provided by employee benefit plans regulated by ERISA, federal law must prevail over state law, and the determination of the benefit mix to be provided by such plans must be allowed to proceed under the protection of federal regulation and the collective bargaining process,[8] unfettered by a state law, the clear purpose of which is *not* to regulate insurance at all but rather to use the financial resources of insurance companies, employers, unions and employee benefit plans to promote the increased utilization of certain health care services and, not incidentally, to protect the financial interests of certain classes of health care providers.

[8] By intruding on the collective bargaining process through which many of the benefits provided under employee benefit plans are determined, mandated health benefit laws also unreasonably interfere with collective bargaining as protected under federal labor law. *Cf. Alessi v. Raybestos-Manhattan, Inc., supra,* 451 U.S. at 525-26, in which this Court observed that where pension plans "emerge from collective bargaining, the additional federal interest in precluding state interference with labor-management negotiations calls for preemption of state efforts to regulate pension terms. [Citations omitted.] As a subject of collective bargaining, pension terms themselves become expressions of federal law, requiring preemption of intrusive state law." By analogy, to the extent the benefit mix in an employee benefit plan is subject to collective bargaining, the state's attempt to interfere with this process by enacting mandated health benefit laws contravenes federal labor policy. The jurisdictional statement of the Appellant The Travelers Insurance Company, to which statement HIAA subscribes completely, addresses this aspect of these appeals in detail.

CONCLUSION

For the reasons stated, probable jurisdiction should be noted.

Respectfully submitted,

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APPENDICES

APPENDIX I

State Laws Affecting Group Health Insurance Coverage

(By State)

	Treatment Coverage[2]		*Provider Coverage*[3]	
	Must Be Included in Group Policies[1]	*Must Be Offered to Group Purchasers*	*Must Be Included in Group Policies*	*Must Be Offered to Group Purchasers*
Alabama	2	1	4	
Alaska			2	
Arizona	3		6	
Arkansas			6	
California	2	5	13	
Colorado	2	1	6	
Connecticut	5	1	1	
Delaware			3	
Florida		3	5	1
Georgia		3	3	
Hawaii			2	
Idaho	1		2	
Illinois	3	1	6	1
Indiana			5	
Iowa				
Kansas		3	4	1
Kentucky		2	4	1
Louisiana		3	6	
Maine	2		3	2
Maryland	4	3	8	
Massachusetts	2		3	
Michigan	3		5	
Minnesota	4		7	
Mississippi	1		5	
Missouri	1	2	6	
Montana	3	1	8	
Nebraska			6	
Nevada	4		3	
New Hampshire	1			
New Jersey	3		4	
New Mexico		2	4	
New York	2	3	6	1
North Carolina			5	

	Treatment Coverage[2]		*Provider Coverage*[3]	
	Must Be Included in Group Policies[1]	*Must Be Offered to Group Purchasers*	*Must Be Included in Group Policies*	*Must Be Offered to Group Purchasers*
North Dakota	3			1
Ohio	3		6	
Oklahoma			3	
Oregon	4		5	
Pennsylvania			5	
Rhode Island	1		2	
South Carolina			2	1
South Dakota		1	5	
Tennessee		3	5	
Texas		2	7	
Utah		1	1	
Vermont		2		
Virginia	2	2	7	1
Washington	2		6	
West Virginia		3	6	
Wisconsin	6		2	
Wyoming			1	
Total	69	48	214	10

[1] Mandated health benefit laws, as that term is used in the text.
[2] Coverage for treatment of a particular illness or disorder or for a particular type of care. See Appendix IIA.
[3] Coverage for services rendered by a particular type of health care provider. See Appendix IIB.

APPENDIX IIA

State Laws Affecting Group Health Insurance Coverage For the Treatment of a Particular Illness or Disorder Or for a Particular Type of Care

	Coverage Must Be Included in Group Policies[1]	*Coverage Must Be Offered to Group Purchasers*	*Total*
Alcoholism	19	13	32
Mental Illness	13	12	25
Drug Abuse	8	7	15
Home Health Care	6	7	13
Mastectomy	7		7
Pregnancy Complications	3		3
Outpatient Care	1	2	3
Nursing Home	1	1	2
Birth Defects	2		2
Kidney Disease	2		2
Emergency	2		2
Rape	2		2
Sickle Cell	1		1
Prenatal Diagnosis		1	1
Diabetic Education		1	1
Rehabilitation		1	1
Occupational Therapy	1		1
Nursery Care		1	1
Hospice Care		1	1
Reconstructive Surgery	1		1
Speech and Hearing		1	1
Total	69	48	117

[1] Mandated health benefit laws, as that term is used in the text.

APPENDIX IIB

State Laws Affecting Group Health Insurance Coverage for Services Rendered by a Particular Type of Health Care Provider

	Coverage Must Be Included in Group Policies	*Coverage Must Be Offered to Group Purchasers*	*Total*
Optometrist	37	2	39
Chiropractor	30	5	35
Dentist	33		33
Podiatrist	30		30
Psychologist	28		28
Osteopath	10		10
Social Worker	6	3	9
Specialized Facilities	9		9
Nurse Midwife	6		6
Registered Nurse	4		4
Nurse Practitioner	3		3
Pharmacist	2		2
Chiropodist	2		2
Physical Therapist	2		2
Audiologist	2		2
Speech Pathologist	2		2
Optician	2		2
Nurse Specialist	1		1
Denturist	1		1
Oral Surgeon	1		1
Counselor	1		1
Occupational Therapist	1		1
Psychiatric Nurse	1		1
Total	214	10	224

APPENDIX III

State Laws Affecting Group Health Insurance Coverage
(By Statute)

Statutory Citation	*Type of Treatment*	*Type of Provider*	*Must Be Included*	*Must Be Offered*
Alabama (Ala. Code)				
§ 27-1-10		Chiropractor	x	
§ 27-1-11		Dentist	x	
§ 27-1-15		Podiatrist	x	
§ 27-1-18	Mental Illness		x	
§ 27-5-13	Sickle-cell		x	
§ 27-19-39		Optometrist	x	
§ 27-20A-1	Alcoholism			x
Alaska (Alaska Stat.)				
§ 21.42.355		Nurse Midwife	x	
§ 21.89.040		Optometrist	x	
Arizona (Ariz. Rev. Stat. Ann.)				
§ 20-1402	Home Health Care		x	
§ 20-1402	Outpatient		x	
§ 20-1406		Optometrist	x	
§ 20-1406		Psychiatric Hospital	x	
§ 20-1406		Podiatrist	x	
§ 20-1406		Dentist	x	
§ 20-1406.01		Psychologist	x	
§ 20-1406.01		Chiropractor	x	
§ 20-1402	Mastectomy		x	
Arkansas (Ark. Stat. Ann.)				
§ 66-3212.2		Optometrist	x	
§ 66-3212.4		Podiatrist	x	
§ 66-3212.6		Psychologist	x	
§ 66-3212.8		Dentist	x	
§ 66-3212.9		Outpatient Surgery Center	x	
§ 66-3212.11		Outpatient Psychiatric Center	x	

Statutory Citation	*Type of Treatment*	*Type of Provider*	*Must Be Included*	*Must Be Offered*
California (Cal. Ins. Code. (West))				
§ 10119.5	Pregnancy Complications		x	
§ 10123.6	Alcoholism			x
§ 10123.8	Mastectomy		x	
§ 10123.9	Prenatal Diagnosis		x	
§ 10123.10	Home Health Care			x
§ 10125	Mental Illness			x
§ 10176		Psychologist	x	
§ 10176		Social Worker	x	
§ 10176		Counselor	x	
§ 10176		Speech Pathologist	x	
§ 10176		Audiologist	x	
§ 10176		Registered Nurse	x	
§ 10176		Chiropractor	x	
§ 10176		Dentist	x	
§ 10176		Podiatrist	x	
§ 10176		Optician	x	
§ 10176		Optometrist	x	
§ 10176		Occupational Therapist	x	
§ 10176.2		Physical Therapist	x	
§ 10176.6	Diabetic Education			x
Colorado (Col. Rev. Stat.)				
§ 10-8-103		Osteopath	x	
§ 10-8-103		Dentist		
§ 10-8-103		Optometrist	x	
§ 10-8-103		Psychologist	x	
§ 10-8-103		Chiropractor	x	
§ 10-8-103		Podiatrist	x	
§ 10-8-116	Mental Illness		x	
§ 10-8-122	Pregnancy Complications		x	
§ 10-8-301	Alcoholism			x
Connecticut (Conn. Gen. Stat. Ann. (West))				
§ 38-174d	Mental Illness		x	

Statutory Citation	*Type of Treatment*	*Type of Provider*	*Must Be Included*	*Must Be Offered*
§ 38-174h		Dentist	x	
§ 38-174i	Accidental Ingestion of Drugs		x	
§ 38-174k	Home Health Care		x	
§ 38-174p	Rehabilitation			x
§ 38-174q	Occupational Therapy		x	
§ 38-262b	Alcoholism		x	
Delaware (Del. Code Ann.)				
24 § 511		Podiatrist	x	
24 § 717		Chiropractor	x	
24 § 2101		Optometrist	x	
Florida (Fla. Stat. Ann. (West))				
§ 627.419		Dentist	x	
§ 627.419		Optometrist	x	
§ 627.419		Podiatrist	x	
§ 627.419		Chiropractor		x
§ 627.6406		Nurse Midwife	x	
§ 627.6616		Ambulatory Surgical Center	x	
§ 627.668	Mental Illness			x
§ 627.669	Alcoholism			x
§ 627.669	Drug Dependency			x
Georgia (Ga. Code)				
§ 33-24-27		Psychologist	x	
§ 33-24-27		Chiropractor	x	
§ 33-24-27.1		Optometrist	x	
§ 33-24-28.1	Mental Illness			x
§ 33-24-28.2	Outpatient Surgery			x
§ 33-24-28.2	Emergency			x
Hawaii (Hawaii Rev. Stat.)				
§ 431-450		Optometrist	x	
§ 431-499		Dentist	x	
Idaho (Idaho Code)				
§ 41-2103		Podiatrist	x	
§ 41-2103		Optometrist	x	
§ 41-2140	Pregnancy Complications		x	

Statutory Citation	*Type of Treatment*	*Type of Provider*	*Must Be Included*	*Must Be Offered*
Illinois (Ill. Ann. Stat. Ins. Code (Smith-Hurd))				
§ 356g	Mastectomy		x	
§ 364		Dentist	x	
§ 364.1		Optometrist		x
§ 367	Alcoholism		x	
§ 367	Rape		x	
§ 367c		Psychiatric Hospital	x	
§ 367d		Rehabilitation Hospital	x	
§ 370b		Osteopath	x	
§ 370b		Chiropractor	x	
§ 370c	Mental Illness			x
§ 370c		Psychologist	x	
Indiana (Ind. Code Ann. (Burns))				
§ 27-8-6-1		Dentist	x	
§ 27-8-6-1		Podiatrist	x	
§ 27-8-6-1		Osteopath	x	
§ 27-8-6-1		Optometrist	x	
§ 27-8-6-1		Chiropractor	x	
Kansas (Kan. Stat. Ann.)				
§ 40-2,100		Optometrist	x	
§ 40-2,100		Dentist	x	
§ 40-2,100		Podiatrist	x	
§ 40-2,104		Psychologist	x	
§ 40-2,105	Alcoholism			x
§ 40-2,105	Drug Abuse			x
§ 40-2,105	Mental Illness			x
§ 40-2,114		Social Worker		x
Kentucky (Ky. Rev. Stat.)				
§ 304.18-033	Newborn Nursey Care			x
§ 304.18-035		Ambulatory Surgical Center	x	
§ 304.18-037	Home Health Care			x
§ 304.18-095		Optometrist	x	
§ 304.18-095		Osteopath	x	

Statutory Citation	*Type of Treatment*	*Type of Provider*	*Must Be Included*	*Must Be Offered*
§ 304.18-095		Chiropractor		x
§ 304.18-097		Dentist	x	
Louisana (La. Rev. Stat. Ann. (West))				
§ 22:213.1		Dentist	x	
§ 22:215.5	Alcoholism			x
§ 22:215.5	Drug Abuse			x
§ 22:662		Podiatrist	x	
§ 22:664		Optometrist	x	
§ 22:665		Psychologist	x	
§ 22:668		Chiropractor	x	
§ 22:669	Mental Illness			x
§ 22:669		Social Worker	x	
Maine (Me. Rev. Stat. Ann.)				
24-A § 2744		Psychologist	x	
24-A § 2744		Social Worker	x	
24-A § 2744		Psychiatric Nurse	x	
24-A § 2840		Chiropractor		x
24-A § 2841		Optometrist		x
24-A § 2842	Alcoholism		x	
24-A § 2842	Drug Abuse		x	
Maryland (Md. Ann. Code Art. 48A)				
§ 470J	Home Health Care		x	
§ 477E	Mental Illness		x	
§ 477M	Short-Term Psychiatric Treatment			x
§ 477-O		Social Worker	x	
§ 477F	Optometrist		x	
§ 477S	Drug Abuse			x
§ 477T		Nurse-Practitioner	x	
§ 477W	Hospice Care			x
§ 477X	Birth Defects		x	
§ 489		Chiropractor	x	
§ 490A		Psychologist	x	
§ 490		Podiatrist	x	
§ 490A-1		Dentist	x	

Statutory Citation	*Type of Treatment*	*Type of Provider*	*Must Be Included*	*Must Be Offered*
§ 490A-2		Nurse Midwife	x	
§ 490F	Alcoholism		x	
Massachusetts (Mass. Gen. Laws. Ann. Ch. 175 (West))				
§ 47B	Mental Illness		x	
§ 108 3		Dentist	x	
§ 110		Optometrist	x	
§ 110	Alcoholism		x	
§ 110		Podiatrist	x	
Michigan (Mich. Comp. Laws Ann.)				
§ 500.2243		Optometrist	x	
§ 500.2239		Dentist	x	
§ 500.3406a	Mastectomy		x	
§ 500.3425	Alcoholism		x	
§ 500.3425	Drug Abuse		x	
§ 500.3475		Psychologist	x	
§ 500.3475		Chiropractor	x	
§ 500.3475		Podiatrist	x	
Minnesota (Minn. Stat. Ann. (West))				
§ 62A.15		Optometrist	x	
§ 62A.15		Chiropractor	x	
§ 62A.15		Registered Nurse	x	
§ 62A.25	Reconstructive Surgery		x	
§ 62A.043		Dentist	x	
§ 62A.043		Podiatrist	x	
§ 62A.149	Alcoholism		x	
§ 62A.149	Drug Abuse		x	
§ 62A.152	Ambulatory Mental Health Care		x	
§ 62A.152		Psychologist	x	
§ 62A.153		Freestanding Ambulatory Surgical Center	x	
Mississippi (Miss. Code Ann.)				
§ 83-9-27	Alcoholism		x	
§ 83-41-203		Optometrist	x	
§ 83-41-209		Dentist	x	
§ 83-41-211		Psychologist	x	

Statutory Citation	*Type of Treatment*	*Type of Provider*	*Must Be Included*	*Must Be Offered*
§ 83-41-213		Nurse Practitioner	x	
§ 83-41-215		Chiropractor	x	
Missouri (Mo. Ann. Stat. (Vernon))				
§ 375.936		Optometrist	x	
§ 375.936		Chiropractor	x	
§ 375.936		Dentist	x	
§ 375.936		Psychologist	x	
§ 375.936		Pharmacist	x	
§ 375.936		Podiatrist	x	
§ 376.381	Mental Illness			x
§ 376.779	Alcoholism		x	
§ 376.779	Drug			x
Montana (Mont. Code Ann.)				
§ 33-22-111		Dentist	x	
§ 33-22-111		Osteopath	x	
§ 33-22-111		Chiropractor	x	
§ 33-22-111		Optometrist	x	
§ 33-22-111		Chiropodist	x	
§ 33-22-111		Psychologist	x	
§ 33-22-111		Nurse Specialist	x	
§ 33-22-111		Pharmacist	x	
§ 33-22-703	Mental Illness		x	
§ 33-22-703	Alcoholism		x	
§ 33-22-703	Drug Addiction		x	
§ 33-22-1002	Home Health Care			x
Nebraska (Neb. Nev. Stat.)				
§ 44-513		Osteopath	x	
§ 44-513		Chiropractor	x	
§ 44-513		Optometrist	x	
§ 44-513		Psychologist	x	
§ 44-513		Dentist	x	
§ 44-513		Podiatrist	x	
Nevada				
§ 689B.30	Home Health Care		x	
§ 689B.30		Hospice	x	
§ 689B.36	Alcoholism		x	

Statutory Citation	Type of Treatment	Type of Provider	Must Be Included	Must Be Offered
§ 689B.36	Drug Abuse		x	
§ 689B.0375	Mastectomy		x	
§ 689B.038		Psychologist	x	
§ 689B.039		Chiropractor	x	
New Hampshire (N.H. Rev. Stat. Ann.)				
§ 415:18A	Mental Illness		x	
New Jersey (N.J. Stat. Ann. (West))				
§ 17B:27-46.1	Alcoholism		x	
§ 17B:27-46.1a	Mastectomy		x	
§ 17B:27-50		Psychologist	x	
§ 17B:27-51		Optometrist	x	
§ 17B:27-51.1		Chiropractor	x	
§ 17B:27-51.4	Home Health Care		x	
§ 17B:27-51.8		Dentist	x	
New Mexico (N.M. Stat. Ann.)				
§ 59-18-19		Optometrist	x	
§ 59-18-19		Psychologist	x	
§ 59-18-19		Podiatrist	x	
§ 59-18-19		Nurse Midwife	x	
§ 59-18-23	Home Health Care			x
§ 59-18-24	Alcoholism			x
New York (N.Y. Ins. Law (McKinney))				
§ 162	Emergency		x	
§ 162	Nursing Home Care			x
§ 162	Ambulatory Care			x
§ 162		Social Worker		x
§ 162	Mental Illness			x
§ 162	Alcoholism		x	
§ 162a		Nurse Midwife	x	
§ 221		Podiatrist	x	
§ 221		Optometrist	x	
§ 221		Dentist	x	
§ 221		Psychologist	x	
§ 221		Chiropractor	x	

Statutory Citation	Type of Treatment	Type of Provider	Must Be Included	Must Be Offered
North Carolina (N.C. Gen. Stat.)				
§ 58-260		Optometrist	x	
§ 58-260		Podiatrist	x	
§ 58-260		Dentist	x	
§ 58-260		Chiropractor	x	
§ 58-260		Psychologist	x	
North Dakota (N.D. Cent. Code Ann.)				
§ 26-03.1-04.1		Chiropractor		x
§ 26-39-03	Mental Illness		x	
§ 26-39-03	Alcoholism		x	
§ 26-39-03	Drug Addiction		x	
Ohio (Ohio Rev. Code Ann. (Baldwin))				
§ 3923.23		Osteopath	x	
§ 3923.23		Optometrist	x	
§ 3923.23		Chiropractor	x	
§ 3923.23		Podiatrist	x	
§ 3923.231	Psychologist		x	
§ 3923.232	Dentist		x	
§ 3923.25	Outpatient Kidney Dialysis		x	
§ 3923.28	Outpatient Mental Illness		x	
§ 3923.29	Alcoholism		x	
Oklahoma (Okla. Stat. Titl. 36)				
§ 3634		Podiatrist	x	
§ 3634		Psychologist	x	
§ 3634		Social Worker	x	
Oregon (Or. Rev. Stat.)				
§ 743.117		Optometrist	x	
§ 743.119	Birth Defects		x	
§ 743.123		Psychologist	x	
§ 743.128		Nurse Practitioner	x	
§ 743.132		Denturist	x	
§ 743.135		Social Worker	x	
§ 743.557	Alcoholism		x	
§ 743.557	Drug Abuse		x	
§ 743.558	Mental Illness		x	

Statutory Citation	Type of Treatment	Type of Provider	Must Be Included	Must Be Offered
Pennsylvania (Pa. Stat. Ann. Tit. 40 (Purdon))				
§ 1511		Osteopath	x	
§ 1511		Dentist	x	
§ 1511		Chiropractor	x	
§ 1511		Podiatrist	x	
§ 1511		Physical Therapist	x	
Rhode Island (R. I. Gen. Laws)				
§ 27-18-25		Chiropractor	x	
§ 27-18-25		Osteopath	x	
§ 27-38-1	Alcoholism		x	
South Carolina (S.C. Code Ann.)				
§ 38-35-90		Podiatrist	x	
§ 38-35-90		Oral Surgeon	x	
§ 38-35-445		Chiropractor		x
South Dakota (S.D. Codified Laws Ann.)				
§ 58.18-7.1	Alcoholism			x
§ 58-17-53		Optometrist	x	
§ 58-17-54		Dentist	x	
§ 58-17-54		Osteopath	x	
§ 58-17-54		Chiropractor	x	
§ 58-17-54		Podiatrist	x	
Tennessee (Tenn. Code Ann.)				
§ 56-7-108		Optometrist	x	
§ 56-7-108		Psychologist	x	
§ 56-7-108		Podiatrist	x	
§ 56-7-116		Chiropractor	x	
§ 56-7-1002		Dentist	x	
§ 56-7-1003	Mental Illness			x
§ 56-7-1003	Alcoholism			x
§ 56-7-1003	Drug Dependence			x
Texas (Tex. Ins. Code Ann. (Vernon))				
§ 3.70-2	Psychiatric Day Treatment			x
§ 3.70-2	Speech and Hearing Impairment			x
§ 21.35A		Psychologist	x	

Statutory Citation	Type of Treatment	Type of Provider	Must Be Included	Must Be Offered
§ 21.52		Podiatrist	x	
§ 21.52		Dentist	x	
§ 21.52		Chiropractor	x	
§ 21.52		Optometrist	x	
§ 21.52		Audiologist	x	
§ 21.52		Speech-Language Pathologist	x	
Utah (Utah Code Ann.)				
§ 31-20-2	Alcoholism			x
§ 31-20-3		Optometrist	x	
Vermont (Vt. Stat. Ann. Tit. 8)				
§ 4089	Mental Illness			x
§ 4096	Home Health Care			x
Virginia (Va. Code)				
§ 38.1-347.1		Chiropractor	x	
§ 38.1-347.1		Optometrist	x	
§ 38.1-347.1		Optician	x	
§ 38.1-347.1		Psychologist	x	
§ 38.1-347.1		Social Worker		x
§ 38.1-347.1		Podiatrist	x	
§ 38.1-347.1		Chiropodist	x	
§ 38.1-348.5		Dentist	x	
§ 38.1-348.7	Mental Illness		x	
§ 38.1-348.8	Alcoholism			x
§ 38.1-348.8	Drug Addiction			x
§ 38.1-348.13	Rape		x	
Washington (Wash. Rev. Code Ann.)				
§ 48.20.390		Podiatrist	x	
§ 48.20.395	Mastectomy		x	
§ 48.20.410		Optometrist	x	
§ 48.20.411		Registered Nurse	x	
§ 48.20.412		Chiropractor	x	
§ 48.20.414		Psychologist	x	
§ 48.20.416		Dentist	x	
§ 48.21.180	Alcholism		x	

Statutory Citation	*Type of Treatment*	*Type of Provider*	*Must Be Included*	*Must Be Offered*
West Virginia (W. Va. Code)				
§ 33-6-30		Dentist	x	
§ 33-6-30		Podiatrist	x	
§ 33-6-30		Chiropractor	x	
§ 33-6-30		Optometrist	x	
§ 33-16-3a	Mental Illness			x
§ 33-16-3b	Home Health Care			x
§ 33-16-3c	Alcoholism			x
§ 33-16-3e		Registered Nurse	x	
§ 33-16-3e		Nurse Midwife	x	
Wisconsin (Wis. Stat. Ann. (West))				
§ 628.33		Chiropractor	x	
§ 632.87		Optometrist	x	
§ 632.89	Alcoholism		x	
§ 632.89	Mental Illness		x	
§ 632.89	Drug Abuse		x	
§ 632.895	Home Health Care		x	
§ 632.895	Skilled Nursing		x	
§ 632.895	Kidney Disease Treatment		x	
Wyoming (Wyo. Stat.)				
§ 26-13-109		Dentist	x	

Supreme Court, U.S.
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(5) (4)

Nos. 84-325, 84-356

IN THE
SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1984

Metropolitan Life Insurance Company,
Appellant
v.
The Attorney General of the Commonwealth
of Massacnusetts,
Appellee

The Travelers Insurance Company,
Appellant
v.
The Attorney General of the Commonwealth
of Massachusetts,
Appellee

Motion To Dismiss The Appellants' Appeals or To Affirm the Judgment of the Supreme Judicial Court of the Commonwealth of Massachusetts

---

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I. QUESTION PRESENTED*

Whether a Massachusetts law requiring that all health insurance policies include minimum mental health coverage (Mass. Gen. Laws ch. 175, §47B) is preempted by the Employee Retirement Income Security Act (ERISA), where ERISA explicitly exempts state insurance laws from its preemption provision. 29 U.S.C. §1144 (b)(2)(A).

* Separate jurisdictional statements have been filed in this case by Metropolitan Life Insurance Company, arguing ERISA preemption, and the Travelers Insurance Company, arguing preemption by the National Labor Relations Act, 29 U.S.C. §§151 et seq. This motion directly addresses only the ERISA issue, as it was the only issue addressed by the Supreme Judicial Court pursuant to the Court's order of remand. (App. C. 10a-12a). With respect to the question of NLRA preemption, the Appellee relies upon and incorporates by

reference his earlier motion to dismiss or affirm, filed September 20, 1982. Metropolitan Life Ins. Co. v. Massachusetts and Travelers Ins. Co. v. Massachusetts, appeals docketed, Nos. 82-299, 82-300 (U.S. Sup. Ct., Aug. 20, 1982). The Attorney General points out, however, that the Supreme Judicial Court's holding with respect to the NLRA appears to have been affirmed implicitly in Belknap Inc. v. Hale, __U.S.___, 103 S. Ct. 3172 (1983) and Brown v. Hotel and Restaurant Employees & Bartenders International Union Local 54, ___U.S.___, 104 S. Ct. 3179 (1984.)

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III. MOTION TO DISMISS THE APPELLANTS' APPEALS OR TO AFFIRM THE JUDGMENT OF THE SUPREME JUDICIAL COURT OF THE COMMONWEALTH OF MASSACHUSETTS

Pursuant to Rule 16 of this Court, the Commonwealth of Massachusetts renews its motion that Appellants' Appeals be dismissed or that the Judgment of the Supreme Judicial Court ("SJC") for the Commonwealth of Massachusetts be affirmed on the grounds that the SJC's decision is plainly correct and the questions presented by the jurisdictional statements are so unsubstantial as to warrant no further argument.

IV. STATEMENT OF THE CASE

In 1973, the Massachusetts General Court enacted a statute, Massachusetts General Laws, chapter 175, §47B (Section 47B), (App. J, 87a-89a), which mandates that all health insurance policies covering Massachusetts residents provide minimum benefits for inpatient and outpatient treatment of mental illness.

A decade later, the Appellant insurance companies ("insurers") attempted to avoid the necessity of writing policies containing Section 47B's benefits by arguing that such state regulation of insurance, a traditional state right, [1/] is preempted by a later-enacted federal

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1/ Insurance regulation is generally reserved for the states. See, e.g. McCarran-Ferguson Act, 15 U.S.C. §§1011, et seq. (App. J, 92a).

law regulating employee welfare plans[2/] and a second law governing collective bargaining.[3/] The insurers assert that employee benefit plans are affected by Section 47B, insofar as such plans purchase health insurance for covered employees,[4/] and that collective bargaining is affected because health insurance benefits may be set in the course of that process. The courts of

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2/ Employee Retirement Income Security Act of 1974, 29 U.S.C. §§1001 et seq. (ERISA) (App. J, 85a-87a).

3/ National Labor Relations Act, 29 U.S.C. §§151 et seq. (NLRA) (App. J, 89a-91a).

4/ No ERISA plan is a party to the case; nor has the Attorney General sought to apply the mandate of Section 47B directly to employee benefit plans. Section 47B, as enforced in this action, applies to insurance policies. See, App. F, 43a.

the Commonwealth have twice rejected these arguments because they founder on the unmistakable intent of Congress not to preempt insurance laws.

That intent is given its clearest exposition in ERISA itself. Throughout the course of this state court litigation the Commonwealth has successfully asserted that Section 47B is exempt from preemption because ERISA's plain language saves from preemption "any law...of any state which regulates insurance". 29 U.S.C. §1144 (b)(2)(A). (App. J, 86a). The courts of the state have consistently reached the same conclusion, albeit by a somewhat narrower reading of the insurance saving clause in ERISA than that proposed here, and only after examining the practical

interplay of Section 47B with ERISA.

The trial court focused on the practical impact of Section 47B on the purposes of ERISA and found no basis for establishing any conflict between Section 47B and ERISA. (App. F, 51a-56a). It rejected arguments by the insurers that varied state insurance laws such as Section 47B would effect a lack of uniformity in multi-state employee benefit plans. Specifically, the trial court found that (1) the administrative burden imposed by mandated benefit laws, including the diversity of eligibility requirements for each state, was no more complex or burdensome to interstate commerce than various other multi-state regulatory schemes such as workmen's compensation laws; (2) the insurers introduced no

credible evidence establishing that the trend toward self-insurance is more pronounced in Massachusetts by virtue of the enactment of Section 47B; and (3) the insurers presented no credible evidence that even assuming every state had enacted mandated benefit laws with varied eligibility requirements, such diversity would be any more complex or burdensome to interstate commerce than various other diverse multi-state regulatory schemes. (App. F. 54a-56a).

With respect to the cost impact of Section 47B on ERISA plans, the court specifically found that (1) the insurers presented no evidence that the insurance companies could not absorb the cost of compliance with Section 47B; (2) they produced no credible evidence that any ERISA plan in the United States had gone

bankrupt because of compliance with a mandated benefit statute; and (3) they produced no credible evidence to establish the actual cost which insurers would incur if they complied with Section 47B. (App. F, 54a-55a).[5/]

The Supreme Judicial Court in its first treatment of the case noted that

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5/ The Appellant Metropolitan's Jurisdictional Statement, however, continues to misrepresent the trial court's findings. It boldly asserts, without citation, that state mandated benefits statutes, such as Section 47B, significantly increase the cost of plan administration, make uniform multi-state ERISA plans far more difficult to achieve and force beneficiaries to choose between paying higher premiums, sacrificing other benefits and foregoing insurance altogether. Jurisdictional Statement of Metropolitan Life Insurance Company, Appellant, at 4, 5, 18, 21, 21 n.11, 23. Such statements are nothing more than public policy arguments which should properly be addressed to Congress or the Massachusetts General Court. Such statements have no support in the Findings and Conclusions of the trial court, (App. F, 36a-62a), and should not be considered by this Court.

ERISA's saving clause for state insurance laws was broad enough to permit a reading saving Section 47B from preemption. Attorney General v. Travelers Ins. Co., 385 Mass. 598 (1982), vacated and rem'd ___U.S.___, 103 S. Ct. 3563 (App. D, 21a). After examining the language of ERISA's preemption and saving clauses and the trial court's finding that the insurers failed to show any actual conflict between ERISA and Section 47B, the SJC held that Section 47B was not preempted. (App. D, 22a, 25a).

On appeal, this Court vacated the SJC's decision and remanded this case for reconsideration in light of its intervening decision in Shaw v. Delta Airlines, 103 S. Ct. 2890 (1983). (App. C, 10a-12a).

On remand, the Supreme Judicial Court again found that ERISA did not preempt Section 47B. Attorney General v. Travelers Ins. Co., 391 Mass. 730 (1984). (App. A, 7a). Considering the case for a second time, now in light of Shaw, the SJC pointed out that Shaw does not address the insurance exemption in ERISA. (App. A, 4a). Using Shaw's analysis that effect must be given to ERISA's plain language, Shaw, 103 S. Ct. at 2900, the court reiterated its previous view that in light of the absence of any conflict between ERISA's purposes and the operation of Section 47B, Section 47B should survive. (App. A, 7a).

The SJC concluded that to read ERISA as preempting Section 47B would be to "read into the statute an intent that is not expressed by plain words or by necessary implication" and would

"require an unnaturally narrow reading of the phrase 'any law . . . which regulates insurance'". (App. A. 6a-7a). The court held that Section 47B was a "bona fide regulation of insurance" and was "within the spirit as well as the letter of the insurance exception to ERISA preemption," and so, should not be preempted. (App. A, 7a). It is that conclusion which the insurance companies ask this Court to reverse.

V. ARGUMENT

A. Summary of Argument

The insurance companies' arguments were properly rejected by the state courts.[1/]

1/ The SJC's decisions are consistent with the determination of the majority

(footnote continued)

The plain language of ERISA exempts insurance laws such as Section 47B from preemption. 29 U.S.C. §1144(b)(2)(A). The contrived reading of the insurance saving clause proffered by the appellants is fashioned without support in the text of ERISA or its legislative history. By specifically including in ERISA the insurance saving clause, which was present in ERISA from its earliest drafts, and by using language which is plain and unambiguous, Congress expressed an explicit and deliberate

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(footnote continued)

of courts which have addressed the same defenses to mandated benefits statutes posed by these same insurance companies. Insurance Comm'r v. Metropolitan Life Ins. Co., 296 Md. 334, 463 A. 2d 793 (1983); Wadsworth v. Whaland, 562 F. 2d 70 (1st Cir. 1977), cert. denied, 435 U.S. 980 (1978); Metropolitan Life Ins. Co. v. Whaland, 119 N.H. 894, 410 A. 2d 635 (1979). See also Eversole v. Metropolitan Life Ins. Co., 500 F. Supp. 1162 (C.D. Cal. 1980).

intent that insurance laws, such as Section 47B, survive preemption. 1 Legislative History of the Employee Retirement Income Security Act of 1974, at 51, 186-187, 634, 3820 (1976).

Finally, the operation of Section 47B works no frustration of the purpose of ERISA. The central aim of ERISA was to defeat fraud, promote disclosure and establish fiduciary standards, 29 U.S.C. §1001 (b)-(c); Alessi v. Raybestos - Manhattan, Inc., 451 U.S. 504, 510 (1981), with a secondary goal of encouraging uniformity in ERISA plans. Shaw, 103 S. Ct. at 2901, 2903; Attorney General v. Travelers Ins. Co., supra (App. D, 24a-25a). By creating exceptions to ERISA preemption of state laws, Congress expressly provided for a

lack of uniformity in ERISA plans among the states. 29 U.S.C. §1144(b). Finally, as Shaw notes, the substantive content of ERISA plans, which is affected by state insurance laws such as Section 47B, was not a concern of Congress when it enacted ERISA. Shaw, 103 S. Ct. at 2897.

B. Appellants' Question Is Not Substantial Because Mass. Gen. Laws ch. 175, §47B Is A Law Which Regulates Insurance And Hence Is Exempt From ERISA Preemption.

Because Section 47B is a law which regulates insurance and hence is exempt from ERISA preemption, this case really presents no issues of constitutional dimension, and characterizing it as a preeemption case is, in a sense, mistaken. Instead, the case involves an

ordinary exercise in statutory construction. Massachusetts asserts that its statute is insulated from a preemption-based challenge because Congress has decreed, as a matter of federal law, that regulation of insurance is best left to the states and is not preempted by ERISA.

If this Court analyzes the matter as a preemption case, however, the analytical framework remains the same. Preemption of state law is not a favored doctrine:

> "Preemption of state law by federal statute or regulation is not favored 'in the absence of persuasive reasons either that the nature of the regulated subject matter permits no other conclusion, or that Congress has so ordained.'" Chicago & North Western Transp. Co. v. Kalo Brick and Tile Co., 450 U.S. 311, 317 (1981), quoting Florida Lime & Avocado Growers v. Paul, 373 U.S.

132, 142 (1963). See Jones v. Rath Packing Co., 430 U.S. 519, 525-526 (1977); Perez v. Campbell, 402 U.S. 637, 649 (1971); Rice v. Santa Fe Elevator Corp., 331 U.S. 218, 230 (1947); Hines v. Davidowitz, 312 U.S. 52, 61-62 (1941).

Alessi v. Raybestos - Manhattan, Inc., supra, 451 U.S. at 522. This is especially true where, as here, the law sought to be preempted lies in an area such as insurance that Congress has specially left to the states to regulate:

> 'we start with the assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress.'

Jones v. Rath Packing Co., 430 U.S. 519, 525 (1977), quoting Rice v. Santa Fe Elevator Corp., 331 U.S. 218, 230 (1947).

Thus, in determining whether Section 47B is preempted, "our task is to

ascertain Congress' intent in enacting the federal statute at issue." Shaw, 103 S. Ct. at 2899. An examination of ERISA and its legislative history leaves no doubt that Congress intended state insurance laws like Secton 47B to survive ERISA preemption.

Whether one is engaged in an ordinary exercise of statutory construction or a preemption analysis, the best indicator of Congressional intent is the wording of the statute involved. Here, the state law, Section 47B, survives mistaken invocation of the Supremacy Clause largely on the strength of ERISA's saving clause for state insurance laws, which provides that:

> Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or

> relieve any person from any law of any State which regulates insurance, banking or securities.

29 U.S.C. §1144(b)(2)(A).

This express limitation on ERISA's otherwise sweeping preemption of state laws exhibits the unmistakable intent of Congress to save state insurance laws. And, for Congress to preserve state insurance laws from preemption comports with the historic delegation to the states of insurance regulation that Congress accomplished through the McCarran-Ferguson Act:

> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance... unless such Act specifically relates to the business of insurance...

15 U.S.C. §1012(b).

As this Court pointed out in Alessi, supra, in enacting ERISA, Congress expressly intended to circumscribe certain areas where state regulation was to be left undisturbed:

> [t]he scope of federal concern [for employee benefit plan regulation] is, however, limited by ERISA itself. The statute explicitly preserves state regulation of "insurance, banking or securities."

Alessi, 451 U.S. at 523 n.19.

Nevertheless, the insurers advance two arguments designed to win preemption of Section 47B. First, the insurers claim that Congress sought through ERISA to mandate uniformity in benefits and administration of employee benefit plans; second, the insurers assert that Section 47B is not an insurance law. But the insurers' arguments fall short

of their mark and twice have been rejected by the SJC.

In its first opinion, the SJC, echoing Alessi, recognized that encouraging uniformity in benefit plans was but one purpose of ERISA:

> Congress undoubtedly contemplated a system of uniform national regulation in the areas governed by ERISA. On the other hand, it specifically approved state regulation in the fields of insurance, banking and securites, and so could not have intended to mandate complete uniformity for the convenience of multi-state employees. Moreover, the Judge below stated in his findings that the defendants had presented "no credible evidence that [diverse State mandatory benefit laws] would be any more complex or burdensome to interstate commerce than various other...multi-state regulatory schemes such as workmen's compensation laws."

Attorney General v. Travelers Ins. Co., supra. (App. D. 24a) (emphasis added).[7/]

In its second opinion, the SJC acknowledged again that uniformity of ERISA plans was a purpose of Congress in enacting ERISA. The SJC noted, however, that an express limitation on the ability of plans to be uniform is created by the "broad language of the insurance exemption." Attorney General v. Travelers Ins. Co., supra. (App. A, 6a). The SJC concluded that "mandated coverage is within the States' traditional authority to regulate

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7/ Such conclusion finds support in Shaw where this Court recognized that in ERISA Congress sought to "minimize," but not eliminate, "the need for interstate employers to administer their plans differently in each State in which they have employees." Shaw, 103 S. Ct. at 2904.

insurance. '[U]nless Congress conveys its purpose clearly, it will not be deemed to have significantly changed the federal-state balance.' United States v. Bass, 404 U.S. 336, 349 (1971). See Wadsworth v. Whaland, supra at 78." Id. (App. A, 6a).

In their second argument, the insurers engage in creative reading and insist that the insurance saving clause applies only to "traditional" insurance laws, not to "any law of any state which regulates insurance." Jurisdictional Statement of Metropolitan at 14-15, 24-25.[8/]

8/ The Commonwealth of Massachusetts has had a long tradition of prescribing the nature of insurance policies, of which Section 47B is but one recent example. As early as 1908, Massachusetts enacted statutes which prescribed provisions to be contained

(footnote continued)

The insurers never define "traditional insurance laws" beyond claiming that:

> In appellant's view, the preemption and [insurance] savings clauses can

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(footnote continued)

in insurance policies. New York Life Insurance Co. v. Hardison, 199 Mass. 190, 85 N.E. 410 (1908). In the area of automobile insurance, Massachusetts pioneered the no-fault system and required auto insurance policies to contain certain provisions. Pinnick v. Cleary, 360 Mass. 1, 271 N.E. 2d 592 (1971). Similarly, compulsory coverage for bodily injury is mandatory in auto insurance in Massachusetts. Insurance Rating Board v. Commissioner of Insurance, 356 Mass. 184, 248 N.E. 2d 500 (1969); In re Opinion of the Justices, 251 Mass. 569, 147 N.E. 681 (1925).

Finally, it is noteworthy that prior to the enactment of ERISA in 1974, at least seven states, including Massachusetts, had already enacted mandated benefits statutes. See Ariz. Rev. Stat. Ann. §20-1402(4)(b) (West Supp. 1983-1984) (enacted in 1971); Conn. Gen. Stat. Ann. §38-174d (West Supp. 1984) (enacted 1971); Ill. Ann. Stat. ch. 73, §979(7) (Smith-Hurd Supp. 1983-1984) (enacted in 1972); Mass. Gen. Laws, ch. 175, §47B (enacted in 1973); Md. Ann. Code art. 48A, §477E (Michie Supp. 1983) (enacted in 1973); Minn. Stat. Ann. §62A.149 (West Supp. 1984) (enacted in 1972); 1971 Wis. Laws ch. 325 (enacted in 1971).

> be sensibly reconciled by confining the latter to the traditional areas of state insurance regulation, such as the specification of standards of conduct in sales and advertising, the prescription of criteria governing investment of funds, and the requirement that adequate reserves be maintained. (citation omitted). This approach, which focuses on the kinds of insurance regulation in which the states have traditionally engaged, permits state regulation in the areas that Congress almost certainly had in mind when it enacted the insurance savings clause. It does so without significantly affecting the operation of ERISA plans.

Jurisdictional Statement of Metropolitan at 24.

It is not surprising that the insurers cite not one statute, case or line of legislative history to support this odd reading of the statutory phrase "any law of any state which regulates insurance." Even the world's most original lexicographer could not concoct a theory

which makes "any" synonymous with "traditional". While Shaw and Alessi counsel resort to the plain language and legislative history of each exception to ERISA's preemption, the insurers offer only their own peculiar notions of public policy to support their tortured reading of the insurance exemption.

In addition to analyzing the language of ERISA's preemption and saving clause, this Court in both Shaw and Alessi carefully considered the effect of the state law in question on the operation and policies of ERISA. Thus in Alessi, the Court struck down a state law which prohibits "set off," a practice which ERISA explicitly permits. Alessi, 451 U.S. at 524-25. And in Shaw, the Court allowed the state

to mandate benefits, even where it might result in a lack of uniformity in ERISA plan administration. Shaw, 103 S. Ct. at 2905-06. The reason: there was no conflict with the purposes of ERISA, and the explicit exception to preemption for state disability laws specially sanctioned such a result. Id. at 2905.

In both cases, the Court carefully looked to legislative history for guidance where the language of the Act was unclear, but where the language was clear, the court adhered to the plain meaning of the language. For instance, in considering whether ERISA preempted the New York Disability Benefits Law,[9/]

9/ In reaching this result the Court emphasized that there was "no reason to torture the plain language of §4(b)(3)[29 U.S.C. §1003(b)(3)]..." Shaw, 103 S. Ct. at 2905.

the plain meaning of the word "solely." coupled with a lack of contrary legislative history, led the Shaw Court to conclude that multi-benefit plans were not sheltered from ERISA preemption. Id. at 2905.10/

Significantly, in upholding the Disability Benefits Law, the Court noted that its ruling permitted a state to require compliance with a mandated benefits law. Id. at 2906. Thus, the Court noted its approval of a statutory scheme that would indirectly dictate the contents of an ERISA plan and thereby detract from uniformity of multi-state benefit plans. Id.

10/ In so ruling, the Court considered an exception to ERISA preemption for "any employee benefit plans...maintained... solely for the purpose of complying with applicable...disability insurance laws." 29 U.S.C. §1003(b)(3) (emphasis added).

The tests of Alessi and Shaw, which are language, intent of Congress as revealed in legislative history, and the practical effect of the state law on the purpose and operation of ERISA, all require that Section 47B, a state insurance law, survive preemption.

VI. CONCLUSION

For the foregoing reasons, the insurance companies' appeals should be dismissed and the decision below should be summarily affirmed.

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In the Supreme Court of the United States

OCTOBER TERM, 1984

METROPOLITAN LIFE INSURANCE COMPANY, APPELLANT

v.

COMMONWEALTH OF MASSACHUSETTS

ON APPEAL FROM THE SUPREME JUDICIAL COURT FOR THE COMMONWEALTH OF MASSACHUSETTS

REPLY BRIEF FOR APPELLANT

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In the Supreme Court of the United States

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No. 84-325

METROPOLITAN LIFE INSURANCE COMPANY, APPELLANT

v.

COMMONWEALTH OF MASSACHUSETTS

ON APPEAL FROM THE SUPREME JUDICIAL COURT FOR THE COMMONWEALTH OF MASSACHUSETTS

REPLY BRIEF FOR APPELLANT

The motion to dismiss or affirm filed by the Commonwealth disregards statutory provisions, judicial decisions, and practical considerations that are central to ERISA preemption issues. In addition, it ignores the congressional choice to leave benefit selection to the private sector; misreads the holding in *Shaw* v. *Delta Air Lines*, 103 S. Ct. 2890 (1983); and wrongly asserts that appellants' arguments are contrary to the trial court record.

1. By assuming throughout its response that Section 47B is a law that "regulates insurance," the Commonwealth begs the very question to be decided.

The question presented in this case is whether Section 47B is a law that "regulates insurance" within the meaning of ERISA's insurance savings clause. The Commonwealth *assumes* an affirmative answer, for the simplistic reason that part of Section 47B affects the content of

health insurance policies. The Commonwealth's approach is erroneous and has already been rejected twice by the Supreme Judicial Court of Massachusetts. Moreover, the Commonwealth completely disregards several factors of undeniable relevance to the issue at hand and seeks to apply the savings clause in a vacuum.

First, the Commonwealth ignores the ERISA preemption clause, its legislative history, and the holdings of this Court regarding the breadth of the clause and the narrowness of its exceptions. These matters are simply not discussed in the Commonwealth's motion. As this Court has observed, Congress deliberately chose to enact an unusually broad preemption provision intended to reach all state laws that "relate to" employee benefit plans. *Shaw* v. *Delta Air Lines, supra*, 103 S. Ct. at 2899-2900, 2903 (1983); *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981).[1] The Court has also held that the exceptions to ERISA preemption are "narrow", "specific", and "very limited". *Shaw* v. *Delta Air Lines, supra*, 103 S. Ct. at 2903. The Commonwealth not only disregards this holding but actually suggests that the insurance savings clause should be construed broadly (Motion 20).[2]

Second, the Commonwealth disregards the true scope and purpose of Section 47B. Having conceded that the

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[1] See also *Hotel and Restaurant Employees and Bartenders International Union Local 54* v. *Danzinger* [*sic*], 536 F. Supp. 317, 333 (D.N.J. 1982) ("The language used by Congress to establish the preemptive effect of ERISA is more comprehensive than Congress usually employs"), rev'd on other grounds, 709 F.2d 815, 830-831 (3d Cir. 1983) (expressly confirming the breadth of ERISA preemption), vacated and remanded on other grounds, 104 S. Ct. 3179 (1984); *Monsanto Co.* v. *Ford*, 534 F. Supp. 51, 53 (E.D. Mo. 1981) ("The broad scope of the language [in] § 1144 indicates a congressional intent to preempt the entire field of law involving employee benefit plans subject to ERISA").

[2] "Motion" refers to the Commonwealth's Motion to Dismiss or Affirm, filed in this Court on October 5, 1984.

portion of Section 47B applying directly to ERISA plans is preempted and cannot be enforced, the Commonwealth acts as if that portion of the statute does not exist and characterizes the remainder of Section 47B as a statute that "regulates insurance." As the language and history of Section 47B show, however, its purpose was to make mental health care widely available, not to regulate insurance. See General Court Joint Committee on Insurance, *Advances in Health Insurance in Massachusetts* (August 1974), summarized in J.S. App. 52a-53a. Whatever the severability of Section 47B may be as a matter of state law, the statute must be viewed as a whole to determine whether it is preempted by ERISA, a *federal* statute.

Third, the Commonwealth blithely disregards the practical consequences of its position. If state mandated benefit laws like Section 47B are held to be laws that regulate insurance within the meaning of ERISA, the states will be free to dictate the entire substantive content of insured ERISA plans, employers will be deprived of the opportunity to maintain uniform, insured multistate plans, and ERISA plans will be encouraged to turn to self-insurance as a way of avoiding proliferating state regulation. The Commonwealth does not deny that these results will occur, but it apparently believes they are irrelevant to the preemption issue presented here. In fact, the consequences listed above are critical. They demonstrate the inconsistencies between the Commonwealth's position and the regulatory scheme that Congress sought to establish in ERISA.[3]

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[3] On two occasions, the Commonwealth refers to the McCarran-Ferguson Act in support of the proposition that "[i]nsurance regulation is generally reserved for the states" (Motion 2 n.1, 17). Appellants have no quarrel with this proposition, but it does not help answer the question presented in this case: Whether the ERISA savings clause permits complete state regulation of the contents of insured ERISA plans. Section 2(b) of the McCarran-Ferguson Act, 15 U.S.C. 1012(b), does not limit the scope of

By insisting on an overbroad, wooden interpretation of the savings clause that has twice been rejected by the court below, and by refusing to defend that court's reasoning in upholding Section 47B, the Commonwealth has highlighted the need for intervention by this Court. Only this Court can provide a definitive resolution that will fix the proper bounds for state regulatory efforts and avoid the need for further repetitive litigation in numerous jurisdictions.

2. Congress left to the private sector the choice of benefits to be provided by ERISA plans.

At several points in its motion to dismiss or affirm, the Commonwealth reflects a fundamental misunderstanding both of appellants' position and of Congress' intent with respect to the substantive content of ERISA plans. The Commonwealth accuses appellants of arguing that "Congress sought through ERISA to *mandate* uniformity in benefits * * * of employee benefit plans" (Motion 18; emphasis added). The Commonwealth goes on to contend that "[b]y creating exceptions to ERISA preemption of state laws, Congress expressly provided for lack of uniformity in ERISA plans among the states" (Motion 12-13).

In fact, however, Congress neither mandated uniformity nor required lack of uniformity. It sought to provide an opportunity for private choice by *enabling* multistate employers to maintain uniform plans. As this Court said in *Shaw*, Congress sought to "minimize[] the need for interstate employers to administer their

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ERISA preemption. As the federal courts have held, to the extent that the McCarran-Ferguson Act would be applicable at all, ERISA falls within the clause in Section 2(b) of the Act that explicitly excepts any federal law that "specifically relates to the business of insurance * * *." See, *e.g.*, *Hewlett-Packard Co.* v. *Barnes*, 571 F.2d 502, 505 (9th Cir.), cert. denied, 439 U.S. 831 (1978). ERISA preemption questions therefore turn solely on the proper construction of ERISA, not the McCarran-Ferguson Act or any other federal statute.

plans differently in each State in which they have employees" (103 S. Ct. at 2904).

It does not follow, as the Commonwealth argues (Motion 13), that merely because ERISA does not itself mandate benefits, Congress was unconcerned with the substantive content of ERISA plans and encouraged lack of uniformity. Congress decided to leave the substantive content of ERISA plans to the private sector and thus to permit uniformity in multistate plans. This opportunity for private choice by plan participants and plan sponsors is precisely what this Court was referring to in *Shaw* when it said that "ERISA does not mandate that employers provide any particular benefits" (103 S. Ct. at 2897). Congress most certainly did not intend, by enacting the insurance savings clause, to allow 50 different states to prescribe 50 different sets of substantive benefits that must be provided by multistate insured ERISA plans.

A recent Sixth Circuit decision strongly supports this point. In *Moore* v. *Reynolds Metal Company Retirement Program For Salaried Employees*, No. 83-3458 (Aug. 10, 1984), the court of appeals stressed that "an employer has no affirmative duty to provide employees with a pension plan. In enacting ERISA, Congress continued its reliance on *voluntary* action by employers" (slip op. 3; emphasis in original, citation omitted). The court ruled that "courts have no authority to decide which benefits employers must confer upon their employees; these are decisions which are more appropriately influenced by forces in the marketplace and, when appropriate, by federal legislation" (*id.* at 4). See also *id.* at 5-6. The limitations recognized in *Moore* on the power of the federal courts to override private choice with respect to the benefits to be provided by ERISA plans are equally applicable to state legislatures. Congress did not intend to permit the states, in the guise of regulating insurance, to override the congressional decision to leave benefit selection to the private sector.

3. The Commonwealth misreads the decision in *Shaw*.

Appellee's treatment of this Court's decision in *Shaw* is erroneous and misleading. Twice, the Commonwealth misstates the holding in *Shaw* in a way that suggests the Court reached a result exactly the opposite of the actual decision. Appellee says that "in *Shaw*, the Court allowed the state to mandate benefits, even where it might result in a lack of uniformity in ERISA plan administration" (Motion 24-25). The Commonwealth further asserts that "the Court noted its approval of a statutory scheme that would indirectly dictate the contents of an ERISA plan and thereby detract from uniformity of multi-state benefit plans" (Motion 26). These summaries pervert *Shaw*'s holding, which was that states may *not* compel employers to include particular disability benefits in ERISA plans. In the Court's words, "the State may not require an employer to alter its ERISA plan" (103 S. Ct. at 2906).

Under Section 4(b)(3) of ERISA, 29 U.S.C. 1003(b)(3), an employee benefit plan maintained *solely* to comply with a state disability insurance law is, by definition, not an ERISA plan and not subject at all to the requirements of the federal statute. In *Shaw*, New York argued, on the basis of Section 4(b)(3), that a state can properly compel a multi-benefit ERISA plan to provide the disability benefits prescribed by state law. This Court disagreed. At most, the Court said, states may require employers to maintain separate plans solely for the purpose of complying with state disability insurance laws. If employers *choose* to comply with such requirements by including disability benefits in their ERISA plans (rather than in a separate plan), they are free to do so. But a state may not *require* employers to follow that course. States may not use Section 4(b)(3)'s exemption for disability plans to deprive the parties to an ERISA plan of their private right to determine the benefits to be included in that plan. Similarly, states cannot rely on Section 4(b)(3) to deny

a multistate employer the option of maintaining a uniform ERISA plan.

4. The factual findings of the trial court are not contrary to appellants' arguments.

Finally, the Commonwealth makes much of certain findings of the trial court and accuses appellant Metropolitan of misrepresenting the trial court's findings (Motion 5-7 and n.5). The accusation is unfounded, and the trial court's findings do not detract from appellants' arguments. Although Massachusetts charges appellant Metropolitan with omitting needed citations (Motion 7 n.5), appropriate record references ar[illegible]cluded in Metropolitan's jurisdictional statement, frequently on the very pages now cited by appellee as the basis of its complaint. See, *e.g.*, 84-325 J.S. 18, 21 n.11, 23. Moreover, and more important, as this Court recognized in *Shaw* (103 S. Ct. at 2904 n.25), the propositions to which the Commonwealth objects are self-evident.

If each state is permitted to dictate a different set of benefits to be included in ERISA plans, it is obvious that maintaining uniform multistate plans will be more difficult. As this Court said in *Shaw* (103 S. Ct. at 2904 n.25), "[o]bligating the employer to satisfy the varied and perhaps conflicting requirements of particular state fair employment laws * * * would make administration of a uniform nationwide plan more difficult."[4] For the same reason, state mandated benefit laws cannot fail to increase the costs of plan administration. The trial court itself expressly acknowledged that mandated benefit stat-

[4] Three witnesses testified at trial about the problems that mandated benefit statutes create for employers seeking to maintain uniform multistate plans. Their testimony was not challenged on cross-examination (A. 95-97, 172, 280-281). The Supreme Judicial Court's opinion on remand (J.S. App. 5a-6a) proceeds on the assumption that mandated benefit statutes *do* conflict with the congressional goal of enabling interstate employers to maintain uniform plans.

utes "do impose an administrative burden" (J.S. App. 54a).[5]

Likewise, there can be no question that mandated benefit statutes will either increase premium costs, or require the sacrifice of other benefits, or cause ERISA plans to become self-insured. Only a finite sum is available to fund employee benefit plans. New benefits cannot be added without costs. That is why the trial court expressly found that "§ 47B will result in additional premium cost" (J.S. App. 51a).[6] And that is why, if the Commonwealth's position is sustained, only plans that forgo the security provided by insurance will be able to avoid higher costs without sacrificing benefits.[7] It is just because these consequences are so clear and so inevitable that both the ERISA Industry Committee ("ERIC") and the Health Insurance Association of America ("HIAA") have submitted amicus briefs in this case, urging the Court to review the ERISA preemption question. See especially ERIC Br. 2-4; HIAA Br. 6-9.

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[5] Three witnesses testified that mandated benefit statutes would increase administrative costs (A. 94-95, 177, 282). They were cross-examined concerning the extent, but not the fact, of such increases.

[6] Several witnesses testified, without contradiction, that mandated benefit statutes would increase premium costs (A. 177-179, 387, 538, 555-556). Similarly, two witnesses testified that employees might choose to trade other benefits for mandated benefits (A. 154, 548-549), and a third described how a particular unwanted trade-off was compelled (A. 86-87). This testimony was undisputed.

[7] Three witnesses testified that self-insurance is a possible response to mandated benefit statutes, and one specifically stated that his employer had considered becoming self-insured because of such statutes (A. 97, 179, 404). Again, this testimony was not contradicted.

CONCLUSION

For all the foregoing reasons, as well as the reasons set forth in appellant's jurisdictional statement, probable jurisdiction should be noted.

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METROPOLITAN LIFE INSURANCE COMPANY, *Appellant*, v. COMMONWEALTH OF MASSACHUSETTS, *Appellee*.	)	No. 84-325
THE TRAVELERS INSURANCE COMPANY, *Appellant*, v. COMMONWEALTH OF MASSACHUSETTS, *Appellee*.	)	No. 84-356

ON APPEAL FROM THE SUPREME JUDICIAL COURT FOR THE COMMONWEALTH OF MASSACHUSETTS

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AMICUS CURIAE BRIEF

ISSUE PRESENTED FOR REVIEW

Whether a state law mandating benefits in insurance policies purchased by employee benefit plans is preempted by § 514 of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1144, or by the National Labor Relations Act, 29 U.S.C. § 151 et seq.

INTEREST OF AMICI CURIAE

This brief filed by Milton R. Hill, et al., supports appellants The Travelers Insurance Company and Metropolitan Life Insurance Company in the above appeals.

Amici are trustees of Sheet Metal Workers Local 16 Health & Welfare Trust, an employee benefit plan established under collective bargaining agreements to provide health care benefits for employees of more than 100 Oregon and Washington employers. In March 1984 the trustees brought an action in the District Court for Oregon to prevent the state's Insurance Commissioner from enforcing statutes mandating benefits in group health insurance policies purchased by multi-employer plans. They alleged that the statutes are preempted by § 514(a) of ERISA, and sought declaratory and injunctive relief. *Hill* v. *Driscoll*, Civ. No. 84-287.[1]

[1] Oregon statutes (Appendix A) mandate benefits in "Group Health Insurance" policies, including policies issued to a multi-employer fund. O.R.S. 743.522(3). The trustees of (footnote continued)

The district court concluded that the Oregon statutes "regulate insurance" and are saved from preemption by § 514(b)(2)(A) of ERISA. It entered summary judgment in favor of defendants, and the trustees appealed to the Ninth Circuit Court of Appeals. Their appeal has been stayed pending a decision of this Court in *Travelers* and *Metropolitan Life*.

Clearly, the decision in *Travelers* and *Metropolitan Life* will be important to a final decision in *Hill* v. *Driscoll*. However, the interests of insurance companies asserted in those cases are not the true measure of their significance to welfare benefit plans under ERISA. The adverse impact on insured plans of state laws mandating benefits in health insurance policies can be severe, as in the case of Local 16, in which the trustees' fiduciary obligations and the economics of the plan they administer make mandated benefits a heavy burden which threatens employers and beneficiaries alike with higher costs and reduced benefits.

SUMMARY OF ARGUMENT

The most serious impact of the decision below is on insured plans which must pay the increased premiums

(footnote carried forward)
Local 16 objected to requirements that their policy provide a specified level of chemical dependency treatment (alcoholism) (O.R.S. 743.557); services of clinical social workers (O.R.S. 743.135); and maxillofacial prosthetic services (O.R.S. 743.119). Those are only some of the benefits mandated by Oregon statutes at the instance of interested groups of providers. See O.R.S. 743.132 (denturist services) and O.R.S. 743.558 (treatment of mental and nervous conditions).

that are generated by mandated benefits. Under that decision, trustees cannot insure a plan's obligations without losing control over benefits and costs, on the untenable ground that the state regulation falls on the policy and not the plan.

This result is hostile to § 514, which, as interpreted in *Alessi*, preempts all state regulation of ERISA plans and relies on the collective bargaining process and decisions of plan fiduciaries to define plan benefits. That federal policy prevents the indirect assertion of state control over ERISA plans by regulating insurance benefits which constitute plan benefits.

ARGUMENT

1. Mandated insurance benefits have a severe adverse effect on benefit plans which, like Local 16's, are not self-insured.[2]

Local 16's plan covers employees of more than 100 employers in the sheet metal industry in Oregon and Washington, and is financed by employers' contributions under collective bargaining agreements. Benefits include hospital/medical and major medical coverages, which are provided under a group health insurance policy from Blue Cross and Blue Shield of Oregon (BC/BSO). The plan is administered by three trustees

[2] The problem facing Local 16's trustees in dealing with the Oregon statutes is reviewed because it illustrates the dilemma of all trustees of insured plans. The affiants are two of the trustees of Local 16's benefit plan. Their affidavits were filed in the summary judgment proceedings in the District Court.

representing employers and three representing the employees. The trustees determine plan benefits and perform administrative functions, and while most benefit decisions are made by consensus (Hill Aff. 6), the employee trustees initiate most benefit changes (Archer Aff. 3).

In recent years, there has been a severe "financial squeeze" on Local 16's plan. The recession reduced employers' contributions by reducing the number of members working and by limiting the available hours of work and the negotiated level of employer contributions per hour worked (Archer Aff. 3-4; Hill Aff. 5). This led to a "squeeze," because the plan pays BC/BSO a full premium for each eligible member and his dependents, although the employer contributes only for hours actually worked (Archer Aff. 4).

This loss of income has been accompanied by "dramatic increases in benefit costs" exceeding the rate of inflation, and as a result plan contributions by employers are less than premiums; reserves are subsidizing current coverage, and reduced benefits are a possibility (Archer Aff. 4-6). From January to October 1983 the average contribution per employee, based on hours worked, was $134.56. The BC/BSO premium per member was $151.71 (Archer Aff. 4).

To deal with these problems, the trustees took two steps. First, they concluded that it would not be prudent to provide coverage on an uninsured basis, and that the plan should provide hospital/medical and

major medical benefits under an insurance policy from BC/BSO (Archer Aff. 2-3; Hill Aff. 5). Proceeding without insurance "would expose our trust and its thousands of beneficiaries to unacceptable risk, especially in view of the current financial squeeze" (Archer Aff. 3; see Hill Aff. 5).

Second, the trustees acted to modify or eliminate certain benefits that Oregon law requires in health insurance policies sold to multi-employer plans. They reduced the benefit for "chemical dependency" (alcoholism) treatment below the level prescribed by statute in 1981 and 1983, and eliminated benefits for the services of clinical social workers and for maxillofacial prosthetic services (Archer Aff. 5; Hill Aff. 6-8). These mandated coverages involve significant costs during a contract period in which increased costs cannot be recovered by increased contributions (Archer Aff. 6).

The continued availability of basic coverages is important to plan members (Hill Aff. 5), and the trustees took these actions only after careful consideration and consultation with their professional advisors and their members, and after evaluating their financial resources (Hill Aff. 2-4, 6; Archer Aff. 6-7).

2. Congress's intent to preempt regulation of ERISA plans is inconsistent with state laws which mandate coverages in insurance policies purchased to provide ERISA plan benefits.

a. The Congressional intent to preempt state regulation of ERISA plans, including plan benefits, has

been given substance by decisions of this Court interpreting § 514 of the Act, *Alessi* v. *Raybestos-Manhattan, Inc.*, (1981) 451 U.S. 504, subject only to "narrow, specific exceptions" in the statute. *Shaw* v. *Delta Air Lines, Inc.*, (1983) — U.S. —, 77 L. Ed.2d 490, 505, 103 S.Ct. 2390. In *Alessi*, a plan which coordinated benefits received under state law was protected by preemption from a state statute forbidding coordination of Workers' Compensation benefits. As applied to an ERISA plan, the statute "related to" the plan and was preempted. Under *Alessi*, the regulation of ERISA plans is "exclusively a federal concern," and benefit decisions are protected from state interference. 451 U.S. at 523-24.

In *Shaw* v. *Delta Airlines, supra*, the Court reviewed the legislative history of ERISA and held that § 514 should be given broad effect, subject only to "narrow, specific exceptions" in the Act.[3] *Shaw* gives no encouragement to the view that those narrow exceptions will be allowed to interfere with the overriding purpose of § 514 to free ERISA plans from state regulation.

b. State mandated insurance benefit statutes unlawfully regulate ERISA benefits by regulating benefits in policies that provide plan benefits. The policy benefits, absent state regulation, reflect the

[3] In *Franchise Tax Bd.* v. *Laborers Vac. Trust*, (1984) — U.S. —, —, n. 26, 77 L. Ed.2d 420, 440, 103 S.Ct. — the Court referred to § 514 as a "virtually unique preemption provision."

decisions of plan fiduciaries acting under collective bargaining agreements and ERISA fiduciary standards, and its provisions defining and limiting policy benefits merely carry out decisions about plan benefits which the State cannot regulate.

Even if this plan had a true choice, and could prudently elect between insuring and self-insuring its obligations, an insurance policy would be an attractive or even important option, by committing to payment of benefits and by providing claim services. In such cases, a plan that wishes to have the benefits of insurance must, like one that has no choice, give up its control over plan benefits and costs if state regulation can mandate policy benefits.

c. For Local 16 the effect is severe. The trustees of Local 16's plan have determined after careful study that prudent management requires them to insure plan benefits and eliminate marginal benefits. Their effort to bring income and expenses into line, while preserving basic coverages for plan members, is threatened with state regulation that imposes costly and unwanted services on their plan.

These trustees face a Hobson's choice. They can take imprudent action and self-insure the plan, or they can provide mandated coverages which exacerbate their financial problem and interfere with their determination of plan benefits. That interference, through the pretense of regulating an essential insurance policy,

dictates plan benefits precisely as if the Oregon law operated directly on the plan itself.

The "narrow, specific exception" in § 514(b)(2)(A) for statutes regulating insurance does not compromise Congress's intent to exclude the states from any role in regulating ERISA plans. State laws mandating insurance benefits are preempted by § 514, because their primary purpose and effect is not to assure the integrity of insurers or the payment of benefits to plan members, but to control plan benefits.

CONCLUSION

Amici support the appeals of *Travelers* and *Metropolitan Life* and ask the Court to reverse the judgment.

Respectfully submitted,

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December 7, 1984

APPENDIX A

O.R.S. 743.522 "Group health insurance" defined.

" 'Group health insurance' means that form of health insurance[4] covering groups of persons as defined in this section, with or without one or more members of their families or one or more of their dependents, or covering one or more members of the families or one or more dependents of such groups of persons, and issued upon one of the following bases:

* * * * *

"(3) Under a policy issued to the trustees of a fund established by two or more employers in the same or related industry or by one or more labor unions or by an association as defined in subsection (2) of this section, which trustees shall be deemed the policy-holder, insuring employes of the employers or members of the unions or of such association, or employes of members of such association for the benefit of persons other than the employers or the unions or such association * * *."

O.R.S. 743.557 Group health insurance coverage for treatment for chemical dependency including alcoholism; limitation on deductibles and coinsurance; eligible treatments and programs; allowable limits on payments; cost containment.

"A group health insurance policy providing coverage for hospital or medical expenses shall provide coverage for expenses arising from treatment for chemical dependency including alcohol-

---

[4] Health insurance is defined in O.R.S. 731.162.

ism. The following conditions apply to the requirement for such coverage:

* * * * *

"(2) Treatment shall include treatment provided in health facilities, residential facilities or outpatient services, as defined in O.R.S. 430.010, within the limits specified in this section. Notwithstanding the limits for particular types of services specified in subsections (6) to (8) of this section, a policy may limit the total of payments for all treatment of any kind under this section for chemical dependency including alcoholism, together with payments for all treatment of any kind under O.R.S. 743.558 for mental or nervous conditions, to $6,000 in any 24-consecutive month period, except as otherwise provided in O.R.S. 743.558. For persons requesting, in any 24-consecutive month period, payments for treatment of any kind for chemical dependency including alcoholism, but not requesting payments for treatment of any kind of mental or nervous conditions, a policy may limit the total of payments for all treatment to $6,000 in that 24-consecutive month period."

O.R.S. 743.135 Reimbursement for services of clinical social worker.

"Whenever any individual or group health insurance policy provides for payment or reimbursement for any service which is within the lawful scope of service of a clinical social worker registered under O.R.S. 675.510 to 675.610:

"(1) The insured under the policy shall be entitled to the services of a clinical social worker registered under O.R.S. 675.510 to 675.610, upon referral by a physician or psychologist."

O.R.S. 743.119 Reimbursement for maxillofacial prosthetic services.

"(1) The Legislative Assembly declares that all group health insurance policies providing hospital, medical or surgical expense benefits include coverage for maxillofacial prosthetic services considered necessary for adjunctive treatment."

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Nos. 84-325 and 84-356

IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

METROPOLITAN LIFE INSURANCE COMPANY,
Appellant,

v.

COMMONWEALTH OF MASSACHUSETTS,
Appellee.

THE TRAVELERS INSURANCE COMPANY,
Appellant,

v.

COMMONWEALTH OF MASSACHUSETTS,
Appellee.

On Appeal From the Supreme Judicial Court of the Commonwealth of Massachusetts

---

BRIEF *AMICUS CURIAE* OF THE BLUE CROSS AND BLUE SHIELD ASSOCIATION

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

No. 84-325

METROPOLITAN LIFE INSURANCE COMPANY,
Appellant,

v.

COMMONWEALTH OF MASSACHUSETTS,
Appellee.

No. 84-356

THE TRAVELERS INSURANCE COMPANY,
Appellant,

v.

COMMONWEALTH OF MASSACHUSETTS,
Appellee.

On Appeal From the Supreme Judicial Court of the Commonwealth of Massachusetts

---

BRIEF *AMICUS CURIAE* OF THE BLUE CROSS AND BLUE SHIELD ASSOCIATION

The Blue Cross and Blue Shield Association submits this brief *amicus curiae* in support of the positions of appellants, Metropolitan Life Insurance Company and The Travelers Insurance Company. Appellants argue, respectively, that the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1001 *et seq.*, and the National Labor Relations Act, 29 U.S.C. §§ 151 *et*

seq., preempt state mandated benefit statutes that apply to insured employee welfare benefit plans. The Blue Cross and Blue Shield Association fully endorses the arguments appellants have presented to the Court.[1]

INTEREST OF THE *AMICUS CURIAE*

The Blue Cross and Blue Shield Association is a non-profit corporation organized under the laws of the State of Illinois. The Association is a membership association that provides central coordinating and administrative services for its ninety-five member Blue Cross and Blue Shield Plans, which also are non-profit corporations. In general, the Plans provide prepaid health benefits to individuals and groups including employee welfare benefit plans, perform as fiscal intermediaries and carriers under the Medicare program, provide services to other non-profit health services organizations, and administer self-insured employee welfare benefit plans.

At the close of 1983, Blue Cross and Blue Shield Plans had approximately 80.4 million subscribers. Of these, approximately 68 million were enrolled in employee welfare benefit plans and, of the 68 million, approximately 15.5 million were enrolled in multistate plans.

ARGUMENT

State mandated benefit laws of the type that are the subject of this litigation increasingly are regulating the benefits that Blue Cross and Blue Shield Plans provide to employee welfare benefit plans. For example, by the end of 1983, 15 states required Blue Cross and Blue Shield Plans to provide benefits for alcoholism treatment; 9, for drug abuse treatment; 12, for the treatment of mental illness; 15, for out-of-hospital care; 4, for breast

[1] All parties have consented in writing to the filing of this brief. Copies of letters from counsel have been lodged with the Clerk of the Court.

reconstruction; and 1, for treatment of cleft lip and palate.[2]

State mandated benefit laws dictate the substantive content of insured employee welfare benefit plans, contrary to the express intent of Congress to preempt "all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). Mandated benefit laws conflict with ERISA's primary purpose—to encourage nationwide uniformity in employee welfare benefit plans. These laws impose on multistate plans a multitude of benefits—differing from one state to the next—which employees often neither want nor need. The state's selection of benefits overrides the benefits chosen by employers and employees, requiring them either to agree to the increased cost or to forego some other benefit already included in the benefit package.

There is no dispute in this case that ERISA prohibits the direct application of mandated benefit laws to self-insured employee welfare benefit plans. *See* 29 U.S.C. § 1144(b)(2)(B). Massachusetts claims, however, that it is free under ERISA to dictate the benefits provided in an insured plan. Since there is no rational reason for making a distinction between insured and self-insured plans, it is inconceivable that Congress could have intended such an arbitrary result.

We wish to bring to the Court's attention another type of state mandated benefit law that may be affected by the Court's decision in this case: mandated provider or "freedom of choice" laws. These laws impose the same burdens on multistate employee benefit plans as are imposed by the state mandated benefit statutes at issue in this case. Freedom of choice laws do not require the insurer to cover a particular medical condition. Rather,

[2] *See generally* Blue Cross and Blue Shield Ass'n, *State Required Health Care Benefits* (June 1984).

they require insurers to provide payment to certain specified types of providers if those providers treat an illness or injury that is already covered in the insurance policy. For example, a Maryland freedom of choice law requires health insurers to pay for treatment rendered by a licensed, certified social worker if the insurer already provides benefits for mental illness.[3] At the end of 1983, 46 states had enacted over 170 freedom of choice laws applicable to Blue Cross and Blue Shield Plans.[4]

The Association, on behalf of its member Plans, is vitally interested in this Court's decision whether mandated benefit laws (and mandated provider laws), as applied to insured employee welfare benefit plans, are preempted by ERISA. We urge the Court to reverse the judgment entered on April 25, 1984, by the Supreme Judicial Court of Massachusetts.

Respectfully submitted,

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December 1984

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[3] Md. Ann. Code art. 48A, § 354L (Supp. 1984). For other examples of freedom of choice laws, see Brief Amicus Curiae of Health Ins. Ass'n. of Am. In Support of Jurisdictional Statements, at App. III, *Metropolitan Life Ins. Co.* v. *Massachusetts*, No. 84-325 (U.S. filed Sept. 29, 1984).

[4] *See generally* Blue Cross and Blue Shield Ass'n, *supra* note 2.

(28) (84)

Nos. 84-325 and 84-356

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In the Supreme Court of the United States

OCTOBER TERM, 1984

METROPOLITAN LIFE INSURANCE COMPANY, APPELLANT
v.
COMMONWEALTH OF MASSACHUSETTS

THE TRAVELERS INSURANCE COMPANY, APPELLANT
v.
COMMONWEALTH OF MASSACHUSETTS

On Appeals from the Supreme Judicial Court for the Commonwealth of Massachusetts

JOINT APPENDIX

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APPEALS DOCKETED AUGUST 30, 1984
PROBABLE JURISDICTION NOTED OCTOBER 29, 1984

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SUPERIOR COURT
DEPARTMENT OF THE TRIAL COURT
FOR CIVIL BUSINESS
SUFFOLK, SS.

Docket No. 35598

COMMONWEALTH OF MASSACHUSETTS, PLAINTIFFS

vs.

THE TRAVELERS INSURANCE COMPANY, AND ANOTHER,
DEFENDANTS

METROPOLITAN LIFE INSURANCE COMPANY

Action #35 Injunction,
#45 Declaratory Judgment and
#47 Consumer Protection

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DOCKET ENTRIES

Date	No.	Entered
1979		
June 1	1	Complaint. Notice ordered issued re: prayer 2 returnable Tuesday, June 26, 1979. Adams, J. (2) Summonses and orders of notice issued.
June 1	—	Civil action cover sheet re: Complaint mailed.
June 15	2	Civil action cover sheet re: Complaint.
June 21	3	Stipulation to enlarge time for defendants to file Answer to and including July 17, 1979.
July 18	4	ANSWER of defendants.
July 23	5	Affidavit of Brooks Joslin.
July 23	6	Affidavit of Jack B. Helitzer, Assistant Vice President of Metropolitan Life Insurance Company.
Aug. 13	7	Memorandum of Decision. Mitchell, J.
Aug. 28	8	ORDER: It is Ordered, Adjudged and Decreed: that upon payment to the Clerk of the sum of $5.00 the application for preliminary injunction is hereby granted. Mitchell, J. Notice sent 8/29/79.

Date	No.	Entered
1979		
Oct. 15	9	Motion of defendant to assign new trial date from November 1979 to January 15-16, 1980.
Oct. 25	—	Motion (P#9) allowed. Lynch, Jr., C.J.
Oct. 25	10	Order: Ordered that action be placed on the without jury list for hearing in the advanced section during the week of January 14, 1980 re: merits. Lynch, Jr., C.J. Notice sent.
1980		
Mar. 21	11	ORDERED: that action be placed on the without jury list for hearing in the advanced section week of June 9, 1980—first case out—in re: merits. Lynch, Jr., C.J. Notice sent 3/24/80.
June 6	12	Joint motion to continue action from June 9, 1980 to July 28, 1980, and allowed. Meyer, J.
July 10	13	Joint motion to continue action to September 22, 1980, and allowed. Meyer, J.
Sept. 22	—	Trial 2nd Session without jury at Cambridge, Brady, J.
Sept. 24	13A	Stipulation, filed by leave. Brady, J.
Sept. 25	13B	Stipulation, filed by leave. Brady, J.
Sept. 25	13C	Supplemental stipulation, filed by leave. Brady, J.
Sept. 29	13D	Second supplemental stipulation, filed by leave. Brady, J.
Oct. 17	14	FINDINGS AND CONCLUSIONS PURSUANT TO MASS. R. CIV. P. 52. Brady, J. Notice sent 10/22/80.

Date	No.	Entered
1980		
Oct. 22	15	JUDGMENT ON FINDINGS BY THE COURT, and approved, Brady, J., entered on Docket pursuant to Mass. R. Civ. P. 58(a) and notice sent to Mass. R. Civ. P. 77(d).
Nov. 14	16	Motion of defendants for temporary relief from Judgment, assented to and allowed. Brady, J.
Nov. 14	—	Motion (P#16) allowed. Brady, J.
Nov. 17	17	Motion of defendant for a stay pending appeal.
Nov. 17	18	Affidavit of Jack B. Helitzer.
Nov. 19	—	Motion (P#17) allowed to stay to November 25, 1980 only, the date of hearing of Commonwealth's motion to amend judgment. Brady, J.
Nov. 19	18A	Points and Authorities in opposition to motion to stay.
Nov. 25	—	Motion (P#17) denied. Brady, J.
Nov. 25	18B	Motion of plaintiff to amend or modify judgment.
Nov. 25	18C	Affidavit of David Schwartz.
Dec. 1	19	JUDGMENT ON FINDINGS BY THE COURT for plaintiff vs. defendants and approved. Brady, J., entered on Docket pursuant to Mass. R. Civ. P. 58(a) and notice sent to parties pursuant to Mass. R. Civ. P. 77(d).
Dec. 3	20	Notice of appeal of defendant The Travelers Insurance Company.
Dec. 3	21	Notice of appeal of defendant Metropolitan Life Insurance Company.

Date	No.	Entered
1980		
Dec. 8	—	Notice to Justice Peter F. Brady of the filing of a notice of appeal.
Dec. 8	—	Notice of service of notice of appeal to Francis X. Bellotti, Attorney General, Sally A. Kelly, Assistant Attorney General, Arthur Leavens, Esquire, and Earle Doppelt, Esquire.
1981		
Apr. 30	22	Transcript of Testimony. (5 Volumes).
May 1	23	Defendants' motion to file annexed certification of transcript and to enlarge time for assembly of record on appeal until May 8, 1981, and allowed. Furnari, J.
May 5	—	Notice of assembly of record on appeal.

COPY,

ATTEST:

/s/ [Illegible]
Assistant Clerk

SUPERIOR COURT
DEPARTMENT OF THE TRIAL COURT

COMMONWEALTH OF MASSACHUSETTS
SUFFOLK, SS

No. 35598

COMMONWEALTH OF MASSACHUSETTS, PLAINTIFF

vs.

THE TRAVELERS INSURANCE COMPANY

and

METROPOLITAN LIFE INSURANCE COMPANY, DEFENDANTS

[Filed Jun. 1, 1979]

COMPLAINT

I. STATEMENT OF THE CASE

1. This action is brought by the Attorney General of the Commonwealth of Massachusetts for declaratory and injunctive relief. The Attorney General seeks to restrain the defendant insurance companies from failing to provide coverage and benefits for treatment of mental and nervous conditions to Massachusetts subscribers of group insurance policies issued by the defendants where such benefits are mandated by G.L. c. 175, § 47B.

II. JURISDICTION

2. Jurisdiction is conferred on the Court by G.L. c. 93A, §4, G.L. c. 12, § 10, G.L. c. 231A, § 1, and G.L. c. 214, § 1.

3. The plaintiff has sent and the defendants have each received a notice, pursuant to G.L. c. 93A, § 4, of the intention of the Attorney General to file suit to enforce the provisions of G.L. c. 175, § 47B.

III. PARTIES

4. The Commonwealth of Massachusetts is a sovereign state of the United States represented by the Attorney General.

5. The Travelers Insurance Company is a corporation duly organized and existing under the laws of the State of Connecticut, with a principal address at One Tower Square, Hartford, and is duly authorized to operate as a foreign insurance company in the Commonwealth.

6. Metropolitan Life Insurance Company is a corporation duly organized and existing under the laws of the State of New York, with a principal address at One Madison Avenue, New York, New York, and is duly authorized to operate as a foreign insurance company in the Commonwealth.

IV. FACTS

7. At all times relevant hereto, the defendant insurance companies have been authorized by the Commissioner of Insurance, pursuant to G.L. c. 175, § 150, to engage in the business of insurance in the Commonwealth. *See* attached Exhibits A and B. The defendants each engage in the business of insurance in the other states of the United States.

8. In the course of its business, each of the defendant insurance companies issues group insurance policies to policyholders which provide hospital and surgical expense for subscribers of the group insurance policies who are residents of the Commonwealth.

9. As used herein, the term "policyholder" generally refers to an employer or employee organization which

provides medical care benefits to employees ("subscribers") through the purchase of group insurance. Such policyholders may qualify as "employee welfare benefit plans" as defined by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1002(1).

10. G.L. c. 175, § 47B was enacted on December 10, 1973, effective January 1, 1976, and provides, in part, as follows:

> Any blanket or general policy of insurance described in subdivision (A), (C), or (D) of section one hundred and ten which provides hospital expense and surgical expense insurance and which is issued or subsequently renewed by agreement between the insurer and the policyholder, within or without the Commonwealth, . . . [shall] provide benefits for expense of residents of the Commonwealth covered under any such policy or plan, arising from mental or nervous conditions . . . which are at least equal to the following minimum requirement:
>
> . . . (c) In the case of outpatients benefits, these shall cover, to the extent of five hundred dollars over a twelve-month period, services furnished (1) by a comprehensive health service organization, (2) by a licensed or accredited hospital, (3) or subject to the approval of the department of mental health services furnished by a community mental health center . . . which furnishes mental health services or (4) consultations or diagnostic or treatment sessions, provided that such services under this clause are rendered by a psychotherapist or by a psychologist licensed under provisions of chapter one hundred and twelve.

11. The defendant insurance companies have issued numerous group insurance policies since January 1, 1976 to policyholders situated outside the Commonwealth

which provide benefits for hospital and surgical expense to subscribers who are residents of the Commonwealth. In each such instance, the defendants have failed to provide Massachusetts resident subscribers the coverage and benefits for mental and nervous conditions mandated by G.L. c. 175 § 47B. *See* Affidavits of Donald Becker, Esquire and Carolyn LaMare attached hereto as Exhibits C and D.

12. The defendant insurance companies have offered to issue group insurance to prospective policyholders outside the Commonwealth which will provide benefits for Massachusetts resident subscribers. The defendants have represented to prospective policyholders that the benefits mandated by G.L. c. 175 § 47B are not required on policies issued outside of the Commonwealth.

13. The defendant insurance companies issued numerous group insurance policies, effective prior to January 1, 1976, which contain no traditional "renewal" clause among the policy terms. However, the defendants retain the right to increase premiums on each such policy. In addition, the defendants and their policyholders may alter other policy terms and benefits by agreement. Such policies have been issued both within and outside the Commonwealth providing coverage to Massachusetts resident subscribers. *See* Affidavit of Donald Becker, Esquire attached hereto as Exhibit C.

14. On information and belief, the defendants have since January 1, 1976 increased the premiums, or altered the policy terms, or both, by agreement with the policyholders of many of the policies described in paragraph 13. The payment and receipt of increased premiums, or alteration of policy terms and benefits constitutes the issuance of a new policy or, alteratively [*sic*], the renewal of the original policy.

15. Where group insurance policies issued by the defendant insurance companies have been renewed or re-

issued since January 1, 1976 through the payment of increased or renewal premiums, or the alteration of policy benefits, the defendants have failed in each such instance to provide to subscribers who are residents of the Commonwealth the coverage and benefits for mental and nervous conditions mandated by G.L. c. 175 § 47B.

16. The defendant insurance companies have denied coverage and benefits mandated by G.L. c. 175 § 47B to Massachusetts residents subscribers of group insurance policies issued by them on various grounds, including:

(a) the policy contains no provision for renewal, and is subject to continuation at the option of the policyholder, and therefore is not subject to § 47;

(b) the policy is issued to a qualified employee welfare benefit plan and, therefore, state law is preempted by ERISA;

(c) § 47B may not be applied extraterritorially to a policy issued outside of Massachusetts. The application of § 47B to a policy issued outside of Massachusetts violates the U.S. Constitution;

(d) where the application of § 47 would have the effect of altering benefits subject to collective bargaining, it is preempted by the National Labor Relations Act. *See* Affidavits of Donald Becker, Esquire and Carolyn LaMare attached hereto as Exhibits C and D.

V. IRREPARABLE INJURY

17. As a result of the failure by the defendants to comply with G.L. c. 175, § 47B, many residents of the Commonwealth have been deterred from obtaining treatment, or have been forced to discontinue treatment for mental and nervous conditions.

VI. CAUSE OF ACTION

18. The defendants have violated G.L. c. 175, §§ 3 and 47B, and G.L. c. 93A, § 2(a) by their failure to provide coverage and benefits for expense of treatment for mental or nervous conditions for residents of the Commonwealth who are subscribers of group insurance policies issued by the defendants.

VII. RELIEF

WHEREFORE, the plaintiff requests that this Honorable Court:

1. Issue an Order of Notice.

2. After return of the order of notice, issue a preliminary injunction restraining the defendants from the failure to provide benefits for expense for treatment of mental or nervous conditions, as required by G.L. c. 175, § 47B, for residents of the Commonwealth who are subscribers of group insurance policies, issued by the defendants within or without the Commonwealth since January 1, 1976.

3. After a hearing on the merits, determine that the defendants have failed to comply with G.1. c. 175, § 47B, and that such failure is a violation of G.L. c. 93A, § 2(a) and G.L. c. 175, § 3.

4. After hearing on the merits, issue a permanent injunction in accordance with prayer 2, and further:

(a) restrain the defendants from failure to provide benefits for expense for treatment of mental or nervous conditions, as required by G.L. c. 175, § 47B, for residents of the Commonwealth who are subscribers of group insurance policies issued by the defendant prior to the effective date of § 47, but which have been reissued or renewed by an increase in premium, or alteration of policy benefits since January 1, 1976.

(b) order that the defendants shall provide notice of the benefits provided by G.L. c. 175, § 47B to each Massachusetts subscriber whose policy is altered by the judgment of the Court in this case.

5. Award the Commonwealth its reasonable costs and attorney's fees.

6. Award such other and further relief as the Court deems just.

COMMONWEALTH OF MASSACHUSETTS
FRANCIS X. BELLOTTI
ATTORNEY GENERAL

BY: /s/ John T. Montgomery
JOHN T. MONTGOMERY
Chief
Insurance Division
Public Protection Bureau
One Ashburton Place
Boston Massachusetts 02108
(617) 727-8048

BY: /s/ Sally A. Kelly
SALLY A. KELLY
Assistant Attorney General
Consumer Products Division
Public Protection Bureau
One Ashburton Place
Boston, Massachusetts 02108
(617) 727-8191

EXHIBIT A

[SEAL]

THE COMMONWEALTH OF MASSACHUSETTS
Division of Insurance
100 Cambridge Street, Boston 02202

TO WHOM IT MAY CONCERN:

THIS IS TO CERTIFY THAT

THE TRAVELERS INSURANCE COMPANY
HARTFORD CONNECTICUT

having complied with the requirements of the laws of this Commonwealth relating to insurance companies, as prescribed by Chapter 175 of the General Laws, was licensed by this Department to transact the business of insurance on July 23, 1864

and has been licensed from that date to the present time.

IT IS FURTHER CERTIFIED THAT the current license, having been issued on July 1, 1978 will expire on June 30, 1979 unless suspended or revoked by this Department prior thereto.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the official seal of this Division at the City of Boston this tenth day May A.D. 1979.

/s/ M.J. Sabbagh
M.J. SABBAGH
Commissioner of Insurance

(The above certificate is issued pursuant to Section 16 of Chapter 175 which prescribes such certificate shall be received by the Courts in lieu of the testimony of the Commissioner.)

EXHIBIT B

[SEAL]

THE COMMONWEALTH OF MASSACHUSETTS
Division of Insurance
100 Cambridge Street, Boston 02202

TO WHOM IT MAY CONCERN:

THIS IS TO CERTIFY THAT

METROPOLITAN LIFE INSURANCE COMPANY
NEW YORK NEW YORK

having complied with the requirements of the laws of this Commonwealth relating to insurance companies, as prescribed by Chapter 175 of the General Laws, was licensed by this Department to transact the business of insurance on November 15, 1866

and has been licensed from that date to the present time.

IT IS FURTHER CERTIFIED THAT the current license, having been issued on July 1, 1978 will expire on June 30, 1979 unless suspended or revoked by this Department prior thereto.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the official seal of this Division at the City of Boston this tenth day of May A.D. 1979.

/s/ M.J. Sabbagh
M.J. SABBAGH
Commissioner of Insurance

(The above certificate is issued pursuant to Section 16 of Chapter 175 which prescribes such certificate shall be received by the Courts in lieu of the testimony of the Commissioner.)

EXHIBIT C

**AFFIDAVIT OF DONALD L. BECKER,
ATTORNEY FOR DIVISION OF INSURANCE**

I, Donald L. Becker, hereby depose and say as follows:

1. I am an attorney on the legal staff of the Massachusetts Division of Insurance, and have worked in that capacity since March, 1977.

2. Throughout the period of my employment with the Division, I have been responsible for enforcing compliance by insurers with Chapter 1174 of the Acts of 1973, which was codified into Chapter 175, Section 47B, Chapter 176A, Section 8A, and Chapter 176B, Section 4A.

3. Chapter 1174 of the Acts of 1973 provides for the inclusion of specified coverages for the treatment of mental illness in health insurance policies, employees health and welfare funds, hospital service contracts, and medical service contracts. On January 1, 1976, the provisions of Chapter 1174 became mandatory on all insurers providing health insurance coverage for Massachusetts residents regardless of whether the policy was issued within or without the Commonwealth.

4. Since 1976, the Division has received numerous complaints from Massachusetts residents alleging noncompliance with the provisions of Chapter 1174 on group insurance policies. Most of these complaints have been against the defendants, Travelers Insurance Company and Metropolitan Life Insurance Company. Letters of denial of coverage have generally stated that the policy in question only provides coverage for treatment by a duly qualified physician, or that because the policy was issued in another state, Chapter 1174 does not apply. Examples are attached hereto as Exhibit C(1).

5. The Division has endeavored to secure compliance with Chapter 1174 through meetings and correspondence with representatives of the defendant-insurers. The defendant-insurers have continued to refuse compliance on the basis of various contentions, including the following: (1) that Massachusetts cannot mandate benefits to be included in policies written in other states, (2) that the Federal Employee Retirement Income Security Act of 1974 denies Massachusetts the right to regulate an employer's employee benefit plan, and (3) that the National Labor Relations Act denies Massachusetts the right to interfere with benefits agreed to pursuant to collective bargaining. Examples of correspondence from the defendant-insurers setting forth these arguments are attached hereto as Exhibit C(2).

6. The Division, after reviewing the complaints against the defendant-insurers alleging noncompliance with Chapter 1174, considered regulatory action to secure enforcement of the statute. However, the Division questioned the appropriateness of the use of its regulatory authority in this situation, particularly in view of the complexity of the issues that would inevitably have to be litigated. Consequently, the Division decided that the best course of action was to defer to litigation to be brought by the Department of the Attorney General in order to obtain a definitive judicial determination of the issue.

7. Judicial review and determination of the issues involved in this matter is essential in order to clarify the rights of Massachusetts residents to the mental health benefits mandated to be provided to them by the terms of Chapter 1174.

8. Both Travelers and Metropolitan derive substantial revenue in Massachusetts from group insurance policies which provide coverage to residents of the Commonwealth. *See* exerpts from the 1978 Annual Statements

filed by each company with the Division of Insurance, and attached hereto as Exhibits C(3) and A(4).

Signed under the PAINS and PENALTIES of PERJURY this 30th day of May, 1979.

/s/ Donald L. Becker
DONALD L. BECKER

EXHIBIT C(1) (a)

[SEAL]

THE TRAVELERS

Group Claim Department
C. J. Keller, Manager

August 8, 1978

North Shore Guidance Center
162 Federal Street
Salem, Ma. 01970
Attention: Leona Pelletier
Insurance Secretary

Subject: GTE Sylvania, Inc.
Group Policy: GA463000AA
Re: Group Health Claim

Dear Ms. Pelletier:

I have received your letter dated June 26, 1978, in regard to services rendered on March 16, 1977 to . In addition, I note your references to Massachusetts General Laws, Chapter 1174.

The subject contract with GTE Sylvania was issued in the State of Delaware and not in the Commonwealth of Massachusetts and, therefore, Chapter 1174 is not applicable.

If you have any further questions, please feel free to contact me.

Sincerely yours,

/s/ Daniel W. Jordan
DANIEL W. JORDAN
Assistant Manager

DWJ:amc

EXHIBIT C(1) (b)

[SEAL]

THE TRAVELERS

December 21, 1976

Group Claim Department
C. J. Keller, Manager
Mary Pederson
Dudley, Mass.

For: Mary
File Number: 493 HS 97398
Policyholder: Curlin Matheson

Dear Miss Pederson:

We have received a statement from William J. Rafferty, Phd. for services rendered.

We regret that we are unable to consider this expense for payment because your group insurance policy allows us to make payment for treatment rendered *only by a duly qualified physician.*

In no way do we question the professional competence or quality of the care received. Our decision is based solely on the policy language which requires that the services be rendered by a duly qualified physician.

Very truly yours,

/s/ Charlene Strok
CHARLENE STROK
Group Claim Processor

CS/dr

CC: Carlin Matheson
110 Commerce Way
Woburn, Mass.

EXHIBIT C(1)(c)

[SEAL]

THE TRAVELERS

Group Claim Department
C. J. Keller, Manager

December 20, 1976

A Y
—— Commonwealth Ave.
Boston, Massachusetts

For: E
File Number:
Policyholder: Boston Globe

Dear Mr. Y

We have received a statement from Hyman L. Kempler, Phd. for services rendered.

We regret that we are unable to consider this expense for payment because your group insurance policy allows us to make payment for treatment rendered *only by a duly qualified physician.*

In no way do we question the professional competence or quality of the care received. Our decision is based solely on the policy language which requires that the services be rendered by a duly qualified physician.

Very truly yours,

/s/ Charlene Strok
CHARLENE STROK
Group Claim Processor

CS/dr

CC: Boston Globe
135 Morrissey Blvd.
Dorchester, Mass.

EXHIBIT C(1)(d)

[SEAL]

THE TRAVELERS
Group Claim Department
C. J. Keller, Manager

January 26, 1977

Chelmsford, Mass. 01824

GTE Sylvania, Inc.
Group Policy Contract GA-463000 AA
Claim No.:
Re:
Group Health Claim

Dear Mr.

We have carefully investigated your claim to see if there was some basis for payment. However, we find it does not meet policy requirements in the sense that the services are not considered "medical care and treatment" for an accidental bodily injury or sickness.

The Group Policy, issued in the State of Delaware, provides coverage for the expense for the performance of out-patient "medical care and treatment" by a physician. While the term "physician" is not limited to a doctor of medicine, it does not include those whose services do not fall with the category of "medical care and treatment" outlined in the policy.

The question has been raised whether this policy is required under the Massachusetts Mental Health Law to cover the type of services provided by Peter Wish, Phd. That law is applicable, upon renewal, to Group Policies issued within or without Massachusetts. This policy is not subject to renewal but is automatically continued so long as the employer continues to pay the premiums. As your employer has not elected to include these statutory

benefits in the policy, we are not in the position to amend unilaterally the Group Policy and charge your claim to the experience of the policyholder. Under the Employee Retirement Income Security Act of 1974, it is questionable whether the Employee Benefit Plan for GTE Sylvania can be required by state statute to provide benefits, or in any other way to regulate the plan.

Should you have any question in this regard, please do not hesitate to contact us.

Very truly yours,

/s/ Charles J. Keller
CHARLES J. KELLER
Manager

CJK:tf

EXHIBIT C(1)(e)

[SEAL]

THE TRAVELERS

Group Claim Department
C. J. Keller, Manager

Needham, MA 02192

March 25, 1977

For:
File Number: 493 HS 19034
Policyholder: GTE Laboratories

Dear Mr.

We have received a statement from Sandra Aizley, M.S.W. for services rendered.

We regret that we are unable to consider this expense for payment because your group insurance policy allows us to make payment for treatment rendered *only by a duly qualified physician.*

In no way do we question the professional competence or quality of the care received. Our decision is based solely on the policy language which requires that the services be rendered by a duly qualified physician.

Very truly yours,

/s/ Daniel W. Jordan
DANIEL W. JORDAN
Assistant Manager

DJ/pr

EXHIBIT C(1)(f)

[SEAL]

THE TRAVELERS

Group Claim Department
C. J. Keller, Manager

July 15, 1977

For
File Number: 493 HS 36150
Policyholder: Fenwal Inc.

Dear

We have received a statement from Ethan Pollack, Ph.D. for services rendered.

We regret thatwe are unable to consider this expense for payment because your group insurance policy allows us to make payment for treatment rendered *only by a duly qualified physician.*

In no way do we question the professional competence or quality of the care received. Our decision is based solely on the policy language which requires that the services be rendered by a duly qualified physician.

Very truly yours,

/s/ M. Lepage
MINDA LEPAGE
Group Claim Processor

CC: Fenwal Inc.
400 Main St.
Ashland, Ma.

ML/dr

EXHIBIT C(1)(g)

[SEAL]

THE TRAVELERS

Group Claim Department
C. J. Keller, Manager

Ocotber 13, 1977

Framingham, Mass.

For:
File Number: 493 HS 41998
Policyholder: GTE Sylvania

Dear Mr.

We have received a statement from Bea Dube, Ph.D. for services rendered.

We regret that we are unable to consider this expense for payment because your group insurance policy allows us to make payment for treatment rendered *only by a duly qualified physician.*

In no way do we question the professional competence or quality of the care received. Our decision is based solely on the policy language which requires that the services be rendered by a duly qualified physician.

Very truly yours,

/s/ Kathleen Farrar
KATHLEEN FARRAR
Group Claims Processor

KF/jp

EXHIBIT C(2) (a)

METROPOLITAN LIFE
One Madison Avenue
New York, N.Y. 10010

George L. White
Vice-President
Government and Industry Relations

Joseph Ciccio, Esq.
Deputy Commissioner
The Commonwealth of Massachusetts
Division of Insurance
100 Cambridge Street
Boston, Massachusetts 22202

Re
Employer: Monsanto
Group No.: 11100-G

Dear Mr. Ciccio

Chief Examiner Moynihan of the Springfield Office asked that I contact you concerning the above case, involving the applicability of Section 47B of Chapter 175 of the Annotated Laws of Massachusetts.

Services were rendered to Mr. Vickers' daughter, Lauri, by a psychologist, Dr. Sidney Hyman on referral from Boston Children's Hospital. Because services rendered by psychologists are not covered under the provisions of the policy issued by Metropolitan to the Monsanto Company, Mr. Vickers' claim was denied. For the reasons referred to hereinafter, we believe that the denial was proper and that Section 47B is not applicable to the policy issued by Metropolitan to the Monsanto Company in Missouri.

Section 47B of Chapter 175 was enacted by the General Court in 1973 and became effective January 1, 1974.

Essentially, it required insurers to offer benefits for coverage of mental illness under certain circumstances. Effective January 1, 1976, such benefits became mandatory. As relevant to the present situation, Section 47B provides:

> Any blanket or general policy of insurance described in subdivision (A), (C), or (D) of section one hundred and ten which provides hospital expense and surgical expense insurance and which is issued or subsequently renewed by agreement between the insurer and the policyholder, within or without the commonwealth, during the period this provision is effective . . . shall . . . provide benefits for expense of residents of the commonwealth covered under any such policy or plan, arising from mental or nervous conditions as described in the standard nomenclature of the American Psychiatric Association which are at least equal to the following minimum requirements:
>
> (c) In the case of outpatient benefits these shall cover, to the extent of five hundred dollars over a twelve-month period, services furnished (1) by a comprehensive health service organization, (2) by a licensed or accredited hospital (3) subject to the approval of the department of mental health services furnished by a community mental health center or other mental health clinic or day care center which furnishes mental health services or (4) consultations or diagnostic or treatment sessions, provided that such services under this clause are rendered by a psychotherapist or by a psychologist licensed under the provisions of chapter one hundred and twelve.

Dr. Hyman is licensed under the provisions of chapter one hundred and twelve.

Section 47B of Chapter 175 is applicable to certain group policies ". . . described in subdivision (A), (C), or (D) of section one hundred and ten which . . . (are) issued

or subsequently renewed by agreement between the insurer and the policyholder, within or without the commonwealth . . ." In our view, Subdivisions (A), (C) and (D) of Section 110 apply only to policies delivered in the Commonwealth. Accordingly, Section 47B should be read to apply only to policies initially issued in Massachusetts which are subsequently renewed, within or without the State.

Also, as pointed out in prior correspondence on this matter, Group Policy No. 11100-G, issued by Metropolitan to the Monsanto Company in Missouri in 1946, does not give Metropolitan the right to non-renew, other than for non-payment of premium. As you may know, it was recently held by the New York Court of Appeals in *HIAA v. Harnett*, a copy of which is attached, that laws made applicable on a policy's renewal cannot be applied to existing policies under which the insurer does not have the right to non-renew. Moreover, the Monsanto policy is not renewed by agreement between Metropolitan and Monsanto. Metropolitan has no choice but to renew the policy; Monsanto continues the existing policy in force by merely continuing to pay the required premiums. For this reason, too, we firmly believe that Section 47B is not applicable to Group Policy 11100-G.

Also, Group Policy 11100-G reflects the results of collective bargaining agreements between Monsanto and the unions representing its employees. Under federal labor policy, statutes like Section 47B cannot alter these negotiated benefits. Additionally, it should be noted that the Monsanto policy is on an excess risk basis under which benefit payments become the liability of the insurance company only when claims exceed a specified trigger point. Then, too, serious constitutional questions arise if the statute is applied extraterritorially to the Monsanto policy which was delivered in Missouri. If the insurance departments attempt to apply these type laws extraterritorially, the resulting balkanization of group insurance

will so increase the cost of administration as to eliminate the very economies which have enabled group insurance to provide low cost coverage for an ever-increasing segment of the population. It will also have the undesirable effect of forcing employers to establish fully self-insured arrangements.

We would be happy to discuss the matter further, should you deem it to be appropriate.

Very truly yours

/s/ G. L. White
Vice-President

July 25, 1978

GLW:11

Attachment

EXHIBIT C(2) (b)

METROPOLITAN LIFE INSURANCE COMPANY

One Madison Avenue
New York, N.Y. 10010

George L. White
Vice-President
Government and Industry Relations

The Honorable James M. Stone
Commissioner of Insurance
The Commonwealth of Massachusetts
Division of Insurance
100 Cambridge Street
Boston, Massachusetts 02202

Attention: Mr. John Petropoulos
Insurance Examiner
Consumer Service Section

Re Family Counseling and Guidance Centers

Dear Commissioner Stone

This will supplement Mr. Morrison's letters of May 16 and July 18, 1978.

We are, of course, aware of the requirements of Chapter 1174 of the laws of 1973, which enacted Section 47B of Chapter 175 of the Annotated Laws. Essentially, it required insurers to offer benefits for coverage of mental illness under certain circumstances. Effective January 1, 1976, such benefits became mandatory. As relevant to the present situation, Section 47B provides:

> Any blanket or general policy of insurance described in subdivision (A), (C), or (D) of section one hundred and ten which provides hospital expense and surgical expense insurance and which is issued or

> subsequently renewed by agreement between the insurer and the policyholder, within or without the commonwealth, during the period this provision is effective . . . shall . . . provide benefits for expense of residents of the commonwealth covered under any such policy or plan, arising from mental or nervous conditions as described in the standard nomenclature of the American Psychiatric Association which are at least equal to the following minimum requirements:
>
> (c) In the case of outpatient benefits these shall cover, to the extent of five hundred dollars over a twelve-month period, services furnished (1) by a comprehensive health service organization, (2) by a licensed or accredited hospital (3) subject to the approval of the department of mental health services furnished by a community mental health center or other mental health clinic or day care center which furnishes mental health services or (4) consultations or diagnostic or treatment sessions, provided that such services under this clause are rendered by a psychotherapist or by a psychologist licensed under the provisions of chapter one hundred and twelve.

Family Counseling and Guidance Centers is a group of approved mental health clinics, wherein treatment was rendered to employees of the General Electric Company.

Section 47B of Chapter 175 is applicable to certain group policies ". . . described in subdivision (A), (C), or (D) of section one hundred and ten which . . . (are) issued or subsequently renewed by agreement between the insurer and the policyholder, within or without the commonwealth . . ." In our view, Subdivisions (A), (C) and (D) of Section 110 apply only to policies delivered in the Commonwealth. Accordingly, Section 47B should be read to apply only to policies initially issued in Massachusetts which are subsequently renewed, within or without the

State. The Group Policy issued by Metropolitan to the General Electric Company was delivered in New York.

Also, as noted above, the requirements of Section 47B are only applicable to policies "issued or renewed (on and after January 1, 1976) by agreement between the insurer and the policyholder,". Since the law became mandatory, the policy issued to General Electric by Metropolitan has not been renewed by agreement between the parties. Rather, General Electric has continued coverage in force by continuation of premium payments. For that reason, it is our view that the statute is not applicable to the General Electric policy.

Also, the Group Policy issued by Metropolitan to General Electric reflects the results of collective bargaining agreements between General Electric and the unions representing its employees. Under federal labor policy, statutes like Section 47B cannot alter these negotiated benefits. Then, too, serious constitutional questions arise if the statute is applied extraterritorially to the General Electric policy which was delivered in New York. If the insurance departments attempt to apply these type laws extraterritorially, the resulting balkanization of group insurance will so increase the cost of administration as to eliminate the very economies which have enabled group insurance to provide low cost coverage for an ever-increasing segment of the population. It will also have the undesirable effect of forcing employers to establish fully self-insured arrangements.

We would be happy to discuss the matter further, should you deem it to be appropriate.

Very truly yours

/s/ G. L. White
Vice-President

August 16, 1978

EXHIBIT C(2)(c)

[SEAL]

THE TRAVELERS
THE TRAVELERS INSURANCE COMPANY
One Tower Square
Hartford, Connecticut 06115

GROUP DEPARTMENT

October 14, 1976

Mr. John Petropoulos
Senior Insurance Examiner
Department of Banking and Insurance
Division of Insurance
Leverett Saltonstall Building
Government Center
100 Cambridge Street
Boston, Massachusetts 02202

Dear Mr. Petropoulos:

Re: Melville Shoe Corporation
—File No. 192 HS 56668

National Standard Corporation
—File No. 192 HS 46610

This will refer to your telephone conversation and correspondence with Supervisor J. E. LeBlanc, Claim Department. Our concern, and I believe yours, has to do with Chapter 1174, L'1973 which provide for coverage for mental illness under a statute which by its terms would attempt to qualify as an extraterritorial statute. The language of the statute refers to hospital expense and surgical expense insurance which is issued or subsequently renewed by agreement between the insurer and the policyholder, within or without the Commonwealth, during the period the provision is effective.

There has been much talk in this correspondence, and presumably in the phone conversations, which indicate The Travelers' Accident and Health Policy is renewable. This is not the case. For a number of years The Travelers' Group Insurance Policy has provided for automatic continuation of the coverage so long as the policyholder pays the premium. One option we have allowed ourselves is to discontinue the policy if, in fact, the requisite participation under state group statutes has not been met.

Otherwise no other alteration of the policy to include new statutory provisions of any state is available to the insurer under these policies. Both of the captioned policies are issued outside of the Commonwealth.

There is another reason to feel this statute may not be enforceable. The policy is issued to cover the employer's obligations as sponsor of an employee welfare benefit plan under Section 402, Employee Retirement Income Security Act of 1974. The policy is not intended to broaden that plan by incorporating coverages not applied for by the employer.

The constitutionality of such a requirement is suspect as interference with contracts concluded in other states and as interference with the collective bargaining process governed by the NLRA. The importance of these arguments is strengthened by the fact that a State's regulatory legislation affecting insurance companies is preempted as to employee benefit plans by Section 514, ERISA. This Section has been tested recently in *Azzaro v. Harnett*, 75 Civ. 3631 (CMM), June 3, 1976 in the United States District Court for the Southern District of New York. The Court concluded that this preemption clause was to be interpreted broadly as precluding the application of state insurance laws and regulations to employee benefit plans. Under the holdings of this decision, it would seem doubtful that, were the matter litigated, a District Court would enforce the inclusion of

the Chapter 1174 benefits in the policy if inclusion of the same benefits in the plan would be considered unenforceable, and this particularly if no premium had been collected for the benefit.

We are, of course, providing for the benefit in policies we issue in Massachusetts.

I trust that this will clarify our position that (1) the policies, issued before the effective date of the Massachusetts law, are not renewable, and for this reason not unilaterally alterable by the insurance company; and (2) the application of the law extraterritorially would not appear supportable under the current interpretation of the Federal law governing employee benefit plans.

Very truly yours,

/s/ H. M. Spencer, Jr.
H. M. SPENCER, JR.
Secretary

HMS:hr

EXHIBIT C(2) (d)

[SEAL]

THE TRAVELERS
THE TRAVELERS INSURANCE COMPANY
One Tower Square
Hartford, Connecticut 06115

GROUP DEPARTMENT

May 26, 1977

Mr. Michael Unger,
Director of Legal Services
State of Massachusetts Insurance Department
Leverett Saltonstall Building
Government Center
100 Cambridge Street
Boston, Massachusetts 02202

Dear Mr. Unger:

Re: GTE Laboratory, Inc.
Group Policy No. GA-463000AC
493-HS-19034

This will serve to acknowledge receipt of your letter of March 15, 1977 to Assistant Manager Jordan of our Danvers, Massachusetts Claim Office.

We wish to refer you to the collective bargaining agreement between the Danvers Plant of GTE Sylvania, Inc. and Teamsters Local No. 42, A/W International Brotherhood of Teamsters, Chauffeurs, Warehousemen and Helpers of America, for the period from September 20, 1976 to September 21, 1979. This collective bargaining agreement, specifically Appendix C—Employee Group Insurance and Benefit Plan, Page 66, provides as follows:

The outpatient psychiatric benefit for employees only shall be improved to provide:

a) payment for the full cost of the first two visits to a clinic or psychiatrist based on reasonable charges,

b) payment of $34.00 for remaining visits to a psychiatrist or $17.00 for clinics.

c) that payment for visits to a clinic or psychiatrist will be limited to the first two visits mentioned in a) above and an additional fifteen visits mentioned in b) above per twelve month benefit period.

d) that a "clinic" will qualify for coverage only if it is affiliated with a state licensed hospital.

The above is the basis for GTE bargaining and benefits throughout the country. The plan of GTE Laboratories Incorporated contains these exact benefits.

We note the language of Section 47B, Chapter 175, of the Massachusetts Statutes, "which is issued or subsequently renewed by agreement between the insurer and the policyholder, *within or without the commonwealth*", modifies the preceding language "Any blanket or general policy of insurance described in subdivision (A), (C), or (D) of section one hundred and ten . . .". Obviously this refers to policies issued in Massachusetts, because a Massachusetts statute cannot mandate the types of policies issued in other states. The GTE policy is issued in Delaware and is subject to the laws of that state.

Furthermore, the GTE policy has not been renewed since the effective date of the statute (January 1, 1976). We stopped renewing our policies many years ago; rather the policy continues in force indefinitely until the policyholder fails to remit premium or gives us notice that it wishes to discontinue. We have no right to unilaterally

alter an existing contract, including its cancellation, except when it no longer meets the requirements of the Delaware statute.

Finally, we note that the obligation under the statute is levied on insurance policies and not on employers. The Employee Retirement Income Security Act of 1974, specifically Section 514, denies to Massachusetts the right to regulate the "employee benefit plan" of GTE. If The Travelers were to provide a mental and nervous benefit under the group insurance policy that an employer has not agreed to, the employer under ERISA could seek to enjoin us in federal court from violating its collective bargaining agreement by providing benefits not provided by its employee benefit plan.

I trust the foregoing will explain our reluctance to attempt to force adherence to your statute.

Sincerely,

/s/ Timothy F. Lyons
TIMOTHY F. LYONS
Assistant Secretary

TFL:hr

cc: Manager Keller, LAG/RAM Claims, Danvers

EXHIBIT C(2)(e)

THE TRAVELERS
THE TRAVELERS INSURANCE COMPANY

[SEAL]

One Tower Square
Hartford, Connecticut 06115

GROUP DEPARTMENT

June 16, 1977

Mr. John Petropoulos
Insurance Examiner
Consumer Service Section
The Commonwealth of Massachusetts
Division of Insurance
Leverett Saltonstall Building
100 Cambridge Street
Boston, Massachusetts 02202

Re: Arthur Sorenson, Exec. V.P.
Communications Workers of America
147 Milk Street, Room 702
Boston, Mass. 02109

Dear Mr. Petropoulos:

We have your May 20 letter regarding the above.

As stated in our previous letter, we believe the reference in Chapter 175, Section 47B of the Massachusetts Laws to a policy described in Subdivision (A), (C), or (D) of Section 110 of Chapter 175, issued or subsequently renewed "within or without the Commonwealth" is limited to a policy originally isssued in the Commonwealth since only such policies are subject to the requirements of Section 110. The Massachusetts legislature cannot mandate provisions to be included in policies issued in other juris-

dictions. Since the policy issued by The Travelers to the American Telephone and Telegraph Company, Long Lines Department was issued in New Jersey, its provisions are subject to the requirements imposed by that state.

Moreover, the mandate under Chapter 175, Section 47B applies to insurance policies not employers. The Employee Retirement Income Security Act of 1974 in Section 514 denies to Massachusetts the right to regulate an employer's "Employee Benefit Plan".

In addition the policy in question reflects the benefit provisions of the Medical-Surgical portion of the Basic Medical Expense Plan, Extraordinary Medical Expense Plan and Special Medical Expense Plan as outlined in the 1974 bargaining agreements between the telephone company and the Communication Workers of America, 1925 K Street N.W., Washington, D.C. 20006. Copies of these agreements are distributed or made available to all individuals covered thereby.

This same question has been raised by one Jonathan Bauer, (dependent Peggy) under a group policy issued to GTE Laboratory, Inc. which has been the subject of correspondence between our company and Mr. Michael Unger, Director of Legal Services for your Department.

While The Travelers stands ready to provide benefits as prescribed by Chapter 175, Section 47B, to any group policyholder, we trust you will appreciate our inability to force a group policyholder to purchase particular benefits or to violate its collective bargaining agreements.

Sincerely,

/s/ Harriett S. Olzendam
HARRIETT S. OLZENDAM
Secretary

HSO:bab

[Exhibits C(3) and C(4) have been omitted. They appear at pages 34 and 35 of the appendix filed by the parties in the Supreme Judicial Court for the Commonwealth of Massachusetts. A copy of that appendix has been lodged with the Clerk of this Court.]

EXHIBIT D

AFFIDAVIT OF CAROLYN A. LAMARRE

1. My name is Carolyn A. LaMarre. I am employed by the Massachusetts Association for Mental Health, Inc. (MAMH), 1 Walnut Street, Boston, as the Liaison to Mental Health Chapters and Mental Health Organizations. I have held this position since 1977.

2. MAMH, formed in 1913, is a private, non-profit citizens organization working for quality mental health care in Massachusetts. The thrust of MAMH's programs is social action and public education. To achieve these objectives, MAMH participates in the planning and implementation of mental health legislation and services; evaluates and develops specific services, and promotes public understanding. MAMH is a division of the National Mental Health Association. Within Massachusetts, MAMH has 26 Affiliated Chapters, 7 Allied Organizations, and works closely with the Coalition of Community Mental Health Partners, a group of 46 state and locally funded mental health clinics.

3. My duties consist of advising mental health organizations on policies, methods, and procedures in matters pertaining to mental health programs as well as providing technical assistance in areas of program development, budgeting, and financing.

4. It came to the attention of MAMH in June, 1977 that the local mental health clinics, jointly financed by state and local funds, were having collection problems with commercial insurance companies under group policies written outside of the Commonwealth of Massachusetts covering Massachusetts resident subscribers. It was our belief that this practice denied residents the benefits required by Chapter 1174 of Acts of 1973.

5. During 1978, I conducted two surveys to assess the impact on the clinics and Massachusetts residents of the

lack of compliance with Chapter 1174. MAMH conducted these surveys with the intention of reporting the results to the Attorney General. In addition to the formal surveys, I spoke to many clinic directors, and employees about this problem.

6. The first survey was conpleted in April, 1978. With 55% of the clinics (26 clinics) responding, 273 instances of nonpayment or partial payment by insurance companies in a 6 month period were identified. From the survey, and from my discussions with the clinics, three basic reasons for nonpayment emerged: (1) companies will not pay for treatment of a Massachusetts resident covered under a group policy issued out of state; (2) companies will not reimburse for treatment provided by licensed psychologists and (3) companies will not apply Chapter 1174 to policies issued prior to January 1, 1976.

7. In the summer and fall of 1978, I conducted a second survey to gather more specific data from selected clinics which had reported extensive nonpayment problems. These clinics were distributed throughout the state. The survey results demonstrated that the Travelers Insurance Company and the Metropolitan Life Insurance Company were consistently failing to provide the Chapter 1174 benefits. The insurance company correspondence solicited by the survey, and attached hereto, show that reason for nonpayment is most often that the contract is issued out-of-state (or the related rationale that services of physicians only are covered). The results of this survey were sent to the Attorney General on December 8, 1978.

8. Clinics have responded to the failure of certain insurance companies to reimburse for the treatment in three different ways: (a) some clinics require that clients with insurance coverage pay the full amount of the fee even though the company refuses to pay. Though it is difficult to determine the extent, it is probable that this policy deters clients from securing clinical services or limits the number of sessions they can afford; (b) some

clinics put the client whose company refuses to pay on a sliding scale fee based on their ability to pay a portion of the total cost for the clinical service; (c) some clinics totally absorb or write off the cost of services to clients whose companies refuse to pay.

9. Where clients are serviced "free" or are subsidized on a sliding scale (8b and c above) the clinic's capacity to serve the community is reduced. Since the money used by the clinics in these situations to cover the deficit of the cost for care is derived from appropriated state reimbursements (see attached letter of the Rate Setting Commission from the Department of Mental Health 8/24/78) or local municipal allocations, the use of these funds for insurance company nonpayment prevents their expenditure for other purposes. All of the clinics citing difficulties with Travelers and Metropolitan have client waiting lists. The use of state and local funds to subsidize insurance nonpayment depletes funds which could otherwise increase staffing to serve those waiting lists. Also if staffing and funds were available, clinics could conduct more outreach and services to citizens who have mental health service needs.

Signed under the PAINS and PENALTIES of PERJURY this 9th day of May, 1979.

/s/ Carolyn A. LaMarre
CAROLYN A. LAMARRE

EXHIBIT D(1)

[SEAL]

THE TRAVELERS

Group Claim Department
C. J. Keller, Manager

August 8, 1978

North Shore Guidance Center
162 Federal Street
Salem, Ma. 01970

Attention: Leona Pelletier
Insurance Secretary

Subject: GTE Sylvania, Inc.
Group Policy: GA463000AA
Re: Group Health Claim

Dear Ms. Pelletier:

I have received your letter dated June 26, 1978, in regard to services rendered on March 16, 1977 to .
In addition, I note your references to Massachusetts General Laws, Chapter 1174.

The subject contract with GTE Sylvania was issued in the State of Delaware and not in the Commonwealth of Massachusetts and, therefore, Chapter 1174 is not applicable.

If you have any further questions, please feel free to contact me.

Sincerly yours,

/s/ Daniel W. Jordan
DANIEL W. JORDAN
Assistant Manager

DWJ:amc

EXHIBIT D(2)

[SEAL]

THE TRAVELERS

Group Claim Department
C. J. Keller, Manager

October 13, 1977

Framington, Mass.

For:
File Number: 493 HS 41998
Policyholder: GTE Sylvania

Dear Mr.

We have received a statement from Bea Dube, Ph.D. for services rendered.

We regret that we are unable to consider this expense for payment because your group insurance policy allows us to make payment for treatment rendered *only by a duly qualified physician.*

In no way do we question the professional competence or quality of the care received. Our decision is based solely on the policy language which requires that the services be rendered by a duly qualified physician.

Very truly yours,

/s/ Kathleen D. Farrar
KATHLEEN FARRAR
Group Claims Processor

KF/jp

EXHIBIT D(3)

METROPOLITAN LIFE INSURANCE COMPANY
402 East Street
Pittsfield, Mass. 01201
Telephone: (413) 447-7336

Frederick C. Bradley
Group Claim Consultant

June 2, 1978

Mr. John S. Greco—Manager
Benefits Accounting &
Claims Administration
Large Transformer Finance Operation
General Electric Company
100 Woodlawn Avenue
Pittsfield, Ma. 01201

Re: 91452

Dear Mr. Greco:

The only psychiatric treatment covered under the General Electric Group Plan is that which is personally administered by a licensed psychiatrist or psychologist.

Therefore, we regret very much that no benefits are payable with regard to the $1155. in fees for therapy provided by Frances Vaughn (even though this treatment was supervised by Dr. Northrup).

Yours truly,

/s/ F. C. Bradley
F. C. BRADLEY
Group Claim Consultant

dmn

EXHIBIT D (4)

[SEAL]

METROPOLITAN LIFE INSURANCE COMPANY
530 Franklin St.
Schenectady, N.Y. 12305
Telephone: (518) 374-9177

Frederick C. Bradley
Group Claim Consultant

PR 14
SS#
7/27/78

Ms. Leona Pelletier
Insurance Secretary
North Shore Guidance Center
and
Health & Education Services, Inc.
162 Federal Street
Salem, Massachusetts 01970

Re: General Electric Company
Policy G-17500

Dear Ms. Pelletier,

Your letter of June 26, 1978 addressed to the General Electric Company has been referred to my attention.

The matter as regards M.G.L. 1973 Chapter 1174, Section 4 is under consideration by the Metropolitan Life Insurance Company's Legal Department together with the Insurance Department of the Commonwealth of Massachusetts. Until the matter is resolved to the mutual satisfaction of both parties, we will continue to process claims in accordance with the provisions of the existing General Electric Company Group Contract.

The General Electric Plan pays benefits on the cost of psychotherapy personally administered by a licensed psychiatrist or a licensed psychologist.

Yours truly,

/s/ Frederick C. Bradley
FREDERICK C. BRADLEY
Group Claim Consultant

COMMONWEALTH OF MASSACHUSETTS
SUPERIOR COURT

Suffolk, ss.

Civil Action No. 35598

COMMONWEALTH OF MASSACHUSETTS, PLAINTIFF

v.

THE TRAVELERS INSURANCE COMPANY

and

METROPOLITAN LIFE INSURANCE COMPANY, DEFENDANTS

[Filed Jul. 16, 1979]

ANSWER OF THE TRAVELERS INSURANCE COMPANY AND METROPOLITAN LIFE INSURANCE COMPANY

First Defense

The defendants, The Travelers Insurance Company and Metropolitan Life Insurance Company, answer the correspondingly numbered paragraphs of the plaintiff's Complant as follows:

1. The defendants admit the allegations contained in the first sentence of paragraph 1. The defendants further admit that the complaint seeks preliminary and permanent injunctions as specified in prayers 2 and 4, respectively. Except as admitted herein, the defendants deny the allegations of paragraph 1.

2. The defendants admit that subject matter jurisdiction is conferred on the Court by G.L. c. 214, § 1. The defendants deny the remaining allegations of paragraph 2.

3. The defendants admit that they have each received notices advising them that the Attorney General intended to file suit, purportedly to enforce the provisions of G.L. c. 175, § 47B. The defendants deny the remaining allegations of paragraph 3.

4-6. The defendants admit the allegations contained in paragraphs 4-6.

7. The defendants admit that they have each been licensed by the Commonwealth of Massachusetts to transact the business of insurance within that state, and that such licenses, issued on a periodic basis, have been regularly in force with regard to each of them for over 100 years. The defendants further admit that each of them transacts the business of insurance in other sovereign states of the United States of America. Except as admitted herein, the defendants deny the allegations of paragraph 7.

8. The defendants admit that in the course of its business each defendant issues group insurance policies, some of which provide coverage for hospital and surgical expense incurred by insureds who are residents of the Commonwealth of Massachusetts. Except as admitted herein, the defendants deny the allegations of paragraph 8.

9. The defendants admit that many of their group insurance policies are issued to implement employee welfare benefit plans. The defendants deny the remaining allegations of paragraph 9.

10. The defendants admit that G.L. c. 175, § 47 B was enacted on December 10, 1973, became effective in its present form on January 1, 1976, and contains, in part, the provisions quoted in paragraph 10 of the Complaint. Except as admitted herein, the defendants deny the allegations of paragraph 10.

11. The defendants admit that since January 1, 1976, they have each issued more than one group insurance policy to policyholders who are situated outside the Common-

wealth of Massachusetts, some of which policies provide coverage for certain hospital and surgical expenses incurred by insureds who are residents of the Commonwealth of Massachusetts. The defendants further admit that certain of these polices do not provide coverage for residents of Massachusetts of all expense arising from the mental or nervous conditions referred to in G.L. c. 175, § 47B. The defendants deny the remaining allegations of paragraph 11.

12. The defendants admit that they have offered to issue group insurance policies to prospective policyholders, some of which are situated outside the Commonwealth of Massachusetts, and that a portion of the potential insureds on some of those policies are residents of the Commonwealth of Massachusetts. The defendants deny the remaining allegations of paragraph 12.

13. The defendants admit that they have issued group insurance policies, effective prior to January 1, 1976, which do not contain provisions affording defendants the unilateral right to non-renew the policies. The defendants admit that such policies provide them with the right to change the premiums. The defendants admit that all the parties to such policies may alter other policy terms and benefits by agreement, and that such policies have been issued both within and outside the Commonwealth providing coverage for insureds who are Massachusetts residents. The defendants deny the remaining allegations of paragraph 13.

14. The defendants admit that since January 1, 1976, each of them has changed the premiums due on some of the policies referred to in their answer to paragraph 13 of the Complaint, and they admit that they have each agreed with some of their policyholders to alter the terms and the premiums of certain other such policies. The defendants deny the remaining allegations of paragraph 14.

15. The defendants admit that certain of the policies referred to in their answer to paragraph 14 of the Complaint do not provide coverage for all expense arising from the mental and nervous conditions referred to by G.L. c. 175, § 47B. The defendants deny the remaining allegations of paragraph 15.

16. The defendants admit that they have responded to requests to provide coverage for certain expenses incurred by some Massachusetts residents stating that the group insurance policies under which those residents are otherwise insured do not provide coverage for all expense arising from the mental and nervous conditions referred to by G.L. c. 175, § 47B, and they admit that those responses were based in part upon the reasons set forth in subparagraphs (a) through (d) of paragraph 16 of the Complaint. The defendants deny the remaining allegations of paragraph 16.

17. The defendants deny the allegations of paragraph 17.

18. The defendants deny the allegations of paragraph 18.

Second Defense

If the statute asserted and relied upon by the plaintiff were to be construed to reach contracts of insurance written to implement employee benefit plans described in § 1003(a) of Title 29 of the United States Code, its application to such contracts would be preempted by and in conflict with the Employee Retirement Income Security Act of 1974, codified in that Title, and the statute would thereby be repugnant to the Constitution and laws of the United States.

Third Defense

If the statute asserted and relied upon by the plaintiff were to be construed to reach contracts of insurance entered into in order to implement collective bargaining

agreements covered by and subject to the federal labor laws, 29 U.S.C. §§ 141 et seq., including the National Labor Relations Act and the Railway Labor Act, its application would be preempted by federal labor law and the statute would thereby be repugnant to the Constitution and laws of the United States.

Fourth Defense

If the statute asserted and relied upon by the plaintiff were to be construed to reach contracts of insurance entered into outside the Commonwealth of Massachusetts, its application would create an unreasonable burden upon interstate commerce such that the statute would be repugnant to the Constitution of the United States.

Fifth Defense

If the statute asserted and relied upn by the plaintiff were to be construed to reach contracts of insurance entered into outside the Commonwealth of Massachusetts, it would constitute an attempted extraterritorial exertion of the Commonwealth's authority repugnant to the due process limitation placed upon the States by the Constitution of the United States.

Sixth Defense

If the statute asserted and relied upon by the plaintiff were to be construed to reach contracts of insurance entered into in and governed by the laws of other sovereign States, its application would constitute an attempted extraterritorial exertion of the Commonwealth's authority repugnant to the Full Faith and Credit Clause of the Constitution of the United States.

Seventh Defense

If the statute asserted and relied upon by the plaintiff were to be construed to reach contracts of insurance

entered into in and governed by the laws of other sovereign States, its application would be an attempted extraterritorial exertion of the Commonwealth's authority in conflict with the sovereign rights reserved to her sister States and repugnant to the Constitution of these United States.

Eighth Defense

If the statute asserted and relied upon by the plaintiff were to be construed to reach contracts of insurance entered into prior to its effective date, it would constitute a law impairing the obligation of contracts repugnant to the Constitution of the United States.

Ninth Defense

Each defendant is exempt from Chapter 93A of the General Laws of Massachusetts by virtue of the provisions of Section 3(1)(b) of that chapter.

Tenth Defense

The plaintiff is guilty of such laches as should in law and equity prevent it from obtaining the relief sought.

By their Attorneys,

/s/ Lane McGovern
LANE MCGOVERN

/s/ William S. Eggeling
WILLIAM S. EGGELING
RICHARD W. SOUTHGATE
ROPES & GRAY
225 Franklin Street
Boston, Massachusetts 02110
(Tel. 617-423-6100)

Attorneys for Defendants
The Travelers Insurance
Company and
Metropolitan Life Insurance
Company

/s/ Arthur Leavens
ARTHUR LEAVENS

/s/ Earl H. Doppelt
EARL H. DOPPELT
JAY GREENFIELD
PAUL, WEISS, RIFKIND, WHARTON
& GARRISON
345 Park Avenue
New York, New York 10022
(Tel. 212-644-8000)

Attorneys for Defendant
Metropolitan Life Insurance
Company

Dated: July 17, 1979

COMMONWEALTH OF MASSACHUSETTS
SUPERIOR COURT
DEPARTMENT OF THE TRIAL COURT

No. 35598

SUFFOLK, SS.

COMMONWEALTH OF MASSACHUSETTS, PLAINTIFF

v.

THE TRAVELERS INSURANCE COMPANY

and

METROPOLITAN LIFE INSURANCE COMPANY, DEFENDANTS

ORDER

This matter came to be heard on the Commonwealth's motion for a preliminary injunction and after a hearing thereon, it is ORDERED, ADJUDGED, and DECREED: that upon payment to the clerk of the sum of $5.00 the application is hereby granted and it is ordered:

Pending the trial and determination of this action, the defendants are restrained from the failure to provide benefits for expense for treatment of mental and nervous conditions, as required by G.L. c. 175 § 47B, for residents of the Commonwealth who are subscribers of group insurance policies, issued by the defendants within or without the Commonwealth since January 1, 1976.

This preliminary injunction shall be implemented as follows:

1. Where a group insurance policy issued by either of the defendants since January 1, 1976 has not provided the benefits required by G.L. c. 175 § 47B at any time since January 1, 1976, the defendants shall, within 30 days of this ORDER, provide to each such policyholder

copies of a notice of benefit changes, and shall provide that such notices be posted by the policyholder in a conspicuous manner and in a sufficient number of locations to provide notice to policy subscribers of the benefit changes implemented by this ORDER. Such notice shall contain the following language in at least 24 point type:

NOTICE OF BENEFIT CHANGES FOR MASSACHUSETTS RESIDENTS

IN ACCORDANCE WITH A PRELIMINARY INJUNCTION ENTERED BY THE SUPERIOR COURT OF MASSACHUSETTS, THE BENEFITS PROVIDED BY (NAME OF GROUP INSURANCE POLICY OR PLAN) FOR MENTAL OR NERVOUS CONDITIONS HAVE BEEN CHANGED FOR MASSACHUSETTS RESIDENTS ONLY. IN ACCORDANCE WITH THE COURT'S ORDER, YOUR POLICY WILL PAY FOR INPATIENT AND OUTPATIENT SERVICES OF MENTAL AND NERVOUS CONDITIONS, SUBJECT TO ANY APPLICABLE DEDUCTIBLE OR COINSURANCE PROVISIONS IN THE POLICY. IN THE CASE OF OUTPATIENT SERVICES, YOU ARE COVERED TO THE EXTENT OF $500 PER YEAR FOR TREATMENT PROVIDED BY 1) A COMPREHENSIVE HEALTH SERVICE ORZANIZATION; 2) A LICENSED HOSPITAL; 3) A LICENSED COMMUNITY MENTAL HEALTH CENTER, MENTAL HEALTH CLINIC OR DAY CARE CENTER WHICH FURNISHES MENTAL HEALTH SERVICES; 4) A LICENSED PSYCHOLOGIST OR PSYCHIATRIST. THIS CHANGE IS APPLICABLE TO ANY CLAIM FOR SUCH SERVICES PROVIDED SINCE JANUARY 1, 1976.

IF YOU RECEIVED TREATMENT FOR A MENTAL OR NERVOUS CONDITION SINCE JANUARY 1, 1976 FOR WHICH YOU DID NOT

RECEIVE PAYMENT UNDER (NAME OF GROUP INSURANCE POLICY OR PLAN), YOU MAY FILE A CLAIM. YOUR CLAIM WILL BE EXAMINED AND IF THE BENEFIT CHANGES DESCRIBED IN THIS NOTICE APPLY, YOUR CLAIM WILL BE PAID.

THIS BENEFIT CHANGE WILL REMAIN IN EFFECT PENDING FINAL RESOLUTION OF THE LITIGATION INSTITUTED BY THE ATTORNEY-GENERAL OF MASSACHUSETTS.

2. Commencing 30 days from the effective date of this order, the defendants shall pay expenses for benefits required by G.L. c. 175, § 47B on claims submitted by subscribers for services rendered at any time since January 1, 1976 on policies issued since January 1, 1976.

/s/ George S. Mitchell, J.
Associate Justice
Superior Court

Entered: August 28, 1979

[TRANSCRIPT OF PROCEEDINGS]

[1-29] TESTIMONY OF JAMES M. DAWSON

DIRECT EXAMINATION
BY MR. GREENFIELD:

Q Please state your name and address.

A My name is James M. Dawson, 51 Platts Avenue, Manchester, New Hampshire.

Q And what is your present employment?

A I'm an administrator of welfare and pension funds.

Q And what is the name of the entity under which you operate?

A I am president of James M. Dawson, Associates, Incorporated of Manchester.

Q And what is the address of that?

A 472 Chestnut Street, Manchester, New Hampshire.

Q Could you describe what the business of James M. Dawson, Associates, Inc. involves?

A Yes, we are in the business of establishing and administering health and welfare plans and pension plans which are negotiated plans between organized labor and their employers.

Q And since when have you been involved in this type [1-30] work?

A Since 1953.

Q What happened in 1953?

A In 1953 I was employed as a plumber, Local 564, and we negotiated the first employee benefit plan that I am aware of in the State of New Hampshire for the plumbers local, and I was asked to be the first administrator for that plan.

Q What were the circumstances that led to your being asked to be the administrator of that plan?

A I was vice-president of the plumbers local. I was also a member of their negotiating bargaining committee, and it was my desire—the members of the union at that

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* The numbers in brackets refer to the page numbers in the trial transcript.

time had no insurance—that they somehow have insurance provided for them by the employer. In fact, plumbers are an itinerant group. They move from employer to employer as the work load presents itself, and for that reason many of them never stayed with one employer long enough to be covered by any insurance plan that that employer might have. And so I conceived of the idea of setting up a trust fund where each employer would pay into that trust for all the hours work for each of his employees, and that trust would be used to purchase [1-31] insurance for the plumbers regardless of which employer they were working for.

We sat down with the employers. We discussed what we wanted for a package of benefits, and after extensive negotiations they finally agreed to give us a minimum package of benefits which they would support with contributions, and a board of trustees under the rules of Taft-Hartley was established. A trust fund was established, and I was selected to be the first administrator as well as one of the trustees of that plan.

Q Did that plan cover plumbers only, or did it also cover steam fitters?

A It covered plumbers and steam fitters.

Q Did you establish welfare plans in trades other than plumbers and steam fitters?

A Yes, I did.

Q Could you tell us in what trades?

A I established them in the masons and bricklayers, plasterers, carpenters, sheet metal workers, electrical workers, painters, and construction drivers.

Q Could you briefly describe how it came about that you established plans for these other trades as well?

A The plumbers plan that we established apparently went [1-32] very well. The unions were very happy with it, and the employers were very happy with it. So some of the other plans came to me and asked me if I would help them to establish a plan between their respective unions and their employers, and I agreed that I would help

them establish. Once the plan was established in each case, they asked me if I would be the administrator.

Q You actually participated in the bargaining negotiations?

A Yes, I actually went to the negotiating table with the unions and sat down and told them what package of benefits—suggested what package was available. In fact, I even went to the union meetings themselves and described with the membership what benefits were available, gave them estimates about what it would cost, discussed rules of eligibility with them, and so forth; and after they had instructed their negotiating team what they wanted, I went with the negotiating team to the employers, explained what the situation was. In each case we were successful in negotiating the conditions for a welfare plan.

Q Now, these various plans that you mentioned in these trades, did any of them exist before you became [1-33] involved with them?

A No, they did not.

Q You formed each one?

A Yes, I did.

Q Are you a member of any industry organization?

A Yes, I am.

Q Which ones?

A The International Society of Professional Benefit Administrators and the International Foundation of Employee Benefit Plans.

Q Could you describe what these associations are?

A The International Foundation of Employee Benefit Plans is an educational organization headquartered outside of Milwaukee in the town of Brookfield, Wisconsin, dedicated entirely to the education of trustees and administrators and professionals in the field of employee benefit plans to the applicable laws and economics of employee benefit plans. The Society of Professional Benefit Administrators is made up entirely of third party contract administrators, as I myself am, and we are concerned with

applicable laws and the problems and so forth involved in the administration of plans.

Q Since when have you been a member of the International [1-34] Foundation?

A I believe in 1947 I joined.

Q '47 or '57.

A 1947 I believe I joined. I'm sorry, no, '57.

Q Do you hold any offices in either of these associations?

A I'm on the Board of Directors of the International Foundation. I am Chairman of their Budget and Finance Committee. I am on their Educational Program Committee. I have previously served as Chairman of their Administrators Committee, was on the Regionals Committee, and I was on their Administrative Cost Study Committee. The Society of Professional Benefit Administrators, I served on the Board of Directors, and I am also chairman of their Preemption Committee.

Q What do you mean by Preemption Committee?

A We are studying the problems of preemption as it refers to administration of plans and seeking ways to solve the problems involved in preemption.

Q Now, are you affiliated with any schools?

A Yes, I am on the Advisory Council of New Hampshire Technical Institute in Concord, New Hampshire.

Q Are you affiliated with any banks?

A Yes, I am on the Board of Directors of the Manchester Bank.

[1-35] Q Are you affiliated with any mental health problems?

A Yes, I am one of the incorporators of the Mancester Mental Health Center.

Q Are you affiliated with any planning committees?

A Yes, I am on the Southern New Hampshire Planning Council.

Q Have you published any articles relating to benefit plans or such subjects?

A Yes, I have. In 1961 I published an article in their textbook for fund administration, published by the International Foundation. In 1970 I published an article in their new textbook on welfare fund administration. I published an article in 1969 in the winter issue of New Hampshire Bar Journal entitled "Role of Attorney in Welfare Pension Funds." In 1976 I wrote an article for the International Digest. In 1977 I published another article in their textbook on welfare fund administration. In 1978 I published an article in the Journal of pension and planning compliance. In 1979 I published an article in the textbook for trustees and administrators of employee benefit plans, and in 1977 I published another article on reciprocity for employee benefit plans. In 1978 I produced an article in Employee Benefits Journal.

[1-36] Q Have you given any speeches in this area?

A Yes, in 1961 I was a speaker at the International Conference of the Foundation. In 1970 I was a speaker. In 1974, 1975, 1977, and 1978 and 1979 and 1980 I was a speaker at various seminars and institutes by the International Foundation?

Q On what subjects?

A On reciprocity, fund administration, ERISA.

Q Now, how many employee welfare funds do you personally administer?

A Eight.

Q Could you tell us the names of those funds and the number of persons covered by them?

A Yes, the New Hampshire-Vermont Mason Health and Welfare Fund has approximately 619 employees with 1,800 dependents. The New Hampshire Construction Drivers have approximately 102 employees with 306 dependents. The Painters Local 1042 has approximately 72 employees and 14 dependents. IBEW, that's Electrical Workers, Local 719—

Q Is that the International Brotherhood of Electrical Workers?

A Yes, it is. 187 employees with 561 dependents. IBEW Local 421, has 90 employees, 270 dependents. Sheet [1-37] Metal Workers 297, 128 employees, 384 dependents; Plumbers Local 131, 944 employees, 2,832 dependents; Northern New Enland [*sic*] Carpenters Health and Welfare Fund, which is a tri-state plan for Maine, New Hampshire, and Vermont, covers 3,285 carpenters and 1,855 dependents.

Q Is it fair to say that the employees in your plans tend to reside in Maine, New Hampshire, and Vermont?

A Yes, they do.

MR. GREENFIELD: Your Honor, I would move that Mr. Dawson be declared an expert in the field of the administrator of employee welfare plans.

THE COURT: Mr. Attorney General?

MR. MONTGOMERY: No objection, your Honor.

THE COURT: Okay.

Q Now, you mentioned the term ERISA. What do you understand ERISA to be?

A ERISA is the Employee Retirement Income Security Act of 1974, a very broad comprehensive law dealing with employee benefit plans, primarily brought about by Congress to protect the interests of the employees and to provide for stability and uniformity in their plans within the United States.

MR. MONTGOMERY: Objection, your Honor. I [1-38] don't believe that Mr. Dawson is qualified to testify with respect to the intent of Congress in enacting that legislation.

THE COURT: That portion may be stricken. The rest may stand, however.

Q Just give your understanding of it, yes. Now, as you understand it, are each of the funds that you administer within ERISA?

A Yes, they are.

Q Are they known as ERISA plans?

A Yes, they are.

Q I think you mentioned the Taft-Hartley. What do you understand in term Taft-Hartley Trust to mean?

A Taft-Hartley refers to the Labor Management Relations Act which I understand to be an act that provides for an exemption from the prohibition against employers contributing anything of value to an employee representative, and the exception is except for contributions to a welfare or pension fund and other funds in there that are also included. They set forth specific conditions. There must be a trust. Labor and management must be equally represented on that trust. Funds for each fund must be kept separate. Basically, I think that's the concept of what a [1-39] Taft-Hartley trust is.

Q And as you understand it, are each of the funds that you administer Taft-Hartley trusts?

A Yes, they are.

Q Now, could you explain in general terms how these funds are established and how they actually operate with respect to benefits?

A Yes. When a group, a union usually, decides that they want to establish a welfare or pension fund, usually the union itself discusses that at the time of negotiations for wage package. Usually I am invited to go to the union meeting and to address the members of the union and discuss with them possible coverages, what those coverages would cost, what their rules of eligibility would be in order that they might have one of these funds; and then normally I am invited to go to the wage negotiations so that the employers might be able to ask me questions that they might have regarding costs and operation of the plan, and so forth. If the unions are successful in negotiating with the employers a contribution to the plan, at that time a board of trustees is selected with equal representation between management and labor, and the trustees, with me helping [1-40] them, usually send the specifications that we have decided on, that is, the package of benefits, to various insurance companies and ask them to bid on the package. After

the sealed bids are received in my office they are reviewed by the trustees, and the insurance providing the best price and conditions are usually selected. At that point an administrator is selected, and, fortunately, in most cases that was our firm.

Q Now, at the bargaining table between the unions and the employers what role do benefit plans play in the actual negotiations?

A Well, we discuss with the employer what we want. We might tell them we want surgical benefits, hospitalization, life insurance, weekly income protection, vision, dental, whatever the package that the union selects they want. Obviously, you don't get everything you ask for. The employers say—it might say, "Fine, we'll give you hospitalization and surgical, but that's all we can afford this time." So, it's actually a tradeoff between what they want and what the employers are willing to give them. So after hard negotiations they wind up with a minimal package and hope that the next time around [1-41] they'll add a few more benefits.

Q Would you say that health benefits play an important or unimportant role in the actual negotiations between employer and employees?

A I would say that the last few years it's one of the dominant roles.

Q What is the reason for that?

A Simply because health care costs have escalated so tremendously, far more than any other segment of our economy, in my personal experience. Therefore, the members are aware of these extremes costs. It's my personal feeling that a person can't afford not to have insurance in this day and age. Consequently most of the members feel that way about it, and to them—I've seen negotiations where no other benefit was discussed other than health care or pensions.

Q With respect to how the actual negotiations take place, could you give the Court an example of what hap-

pens, taking for that example, perhaps, the recent negotiations with the plumbers?

A Well, the plumbers came into their negotiations, and they felt that they would need a dental program that would provide a maximum of $1,000 a year for each member and their dependents. They felt that they [1-42] needed a maximum of $125 for a pair of glasses, and normally they are allowed one pair of glasses every two years in most of our plans. When the negotiations were all over, they received from their employer enough to pay for $200 maximum for the member, $200 for his spouse, and $100 for each child under a dental program. They received a maximum of $75 for any member every two years on the vision.

Q Now, you referred earlier to the fact that you actually attended union meetings at which benefits are discussed. Could you describe in general the nature of those discussions?

A Well, I go to the union meetings, and we tell them—we suggest to them the various types of coverages that are available to us. Some coverages they turn thumbs down on absolutely. They are not interested at all. Other benefits they feel—you have a man stand up and say, "Lookit, I've got a child at my house that's got a mouth full of cavities, and I certainly feel we've got to provide dental coverage." Another young fellow, particularly, will get up and say, "Lookit, I think maternity benefits are an absolute must in this particular case." Somebody else will say, "Lookit, I've got a child here that [1-43] can't even get passing grades in school because she needs a pair of glasses so bad, and I can't afford the pair of glasses." That's the type of give and take that you have at the union meeting where members actually get up and vocalize very vehemently about what they personally feel is needed in their particular family. After the discussions are all over, the union actually takes a vote, and the predominent view prevails.

Q The predominent view as to which benefits to seek?

A That's right.

Q Has anyone at any of these meetings ever expressed a need or desire for mental health benefits?

A No, they haven't.

MR. MONTGOMERY: Objection.

THE COURT: I'll allow it.

Q Now, you used earlier the term "eligibility list." Could you tell the Court what an eligibility list is and the role that it plays in the negotiating and in the actual administration of welfare plans?

A Yes, I will. Obviously every one of these benefits that the union asks for has a cost attached to it. In order to be able to determine what number of cents per hour an employer would have to contribute on behalf of their members—As I previously explained, [1-44] these are itinerant workers who may work two or three weeks for one employer and then go to someplace else. So no employer is going to say, "I'm going to pay the cost of that particular program" because the worker doesn't stay with him long enough, so it has to be based on a cents per hour. Now, in order to intelligently decide how many cents per hour we are going to have to tell the union they need, we have to know how many hours they are going to agree that they have to work in a given period. Normally, in the construction industry we divide the eligibility into two periods a year, every six months. So then the decision has to be made of how many hours we will require an employee to work in a six-months period. Now, initially most of these plans had either 400 or 600 hours in a six-months period in order to become insured. Now, that meant that a person would only have to work about half time because if a person were to work six months at full time, he would work approximately 1,020 hours in that period of time. Now, if you require him to work 600 hours, we would normally expect that most of them could work 600 hours, so most of the plans with one or two exceptions were set at 600

hours for eligibility. [1-45] So an employee who worked 600 hours in a six-month period was then insured for the next following six-month period.

Q Now, if an employee meets the eligibility list requirements, he is then eligible for the full benefits?

A That's right.

Q And if he does not meet the eligibility requirements, what happens?

A He loses his insurance.

Q Now, at some point in the process of obtaining benefits for your plan, does insurance come in?

A Yes, everyone of the plans that I administer is insured.

A And you obtain bids from the various insurance carriers that you consider responsible?

A Yes.

Q Then you select that bid which is most favorable?

A That's right.

Q Now, what types of insurance policies do you enter into?

A Well, what we call experience rated policies.

Q Would you describe what that is?

A Yes, an experience rated policy is where that fund stands on its own feet as opposed to community rating. In other words, at the end of the year the insurance [1-46] company will actually come to us. Take the Carpenters Fund. In round figures they would pay the insurance company in premiums in one year approximately a million dollars. Now, at the end of the year the insurance company is going to come back to them and say to them, "You had in claims and retentions—" because that's part of the cost from the insurance company "—you had in claims and retentions $800,000. Therefore, we are going to give you a refund." They actually write us a check and give us a refund for $200,000 because that's the difference. However, if the experience is bad, the fund will then either be hit with a charge with whatever the excess is, $100,000 or so forth, or they

would run a deficit which will be carried forward to the next year and probably a rate increase, so that the $100,000 deficit will be recouped in a reasonable period of time.

Q Now, if it turns out that the amount paid in benefits by the insurance company is greater than the amount of premiums, as you understand it are you free to walk away from the policy and leave the insurance company holding the bag for that difference?

A Yes, we can.

Q Have there been occasions when the amount paid by [1-47] the insurance company exceeded the amount of the premiums?

A Yes, I can think of one particular case, two particular cases. At one particular time the carpenters were in the red, if you will accept that expression, for $325,000.

Q Do you mean by that that the claims paid exceeded the premiums by $350,000?

A That's right.

Q Continue.

A The masons just a short time ago, last year, ran up a deficit of $64,000.

Q Now, with respect to the carpenters, did you give consideration to changing carriers and leaving—Who was the carrier?

A The Lincoln National Life Insurance Company.

Q Did you give consideration to changing carriers and leaving Lincoln holding what we'll say is the bag for that $350,000?

A The trustees discussed it extensively.

Q And was something done similarly with the masons?

A Yes, it was.

Q Generally, what is the duration of the insurance policy that you buy?

[1-48] A One year contracts.

Q And how often are premiums paid?

A Semi-annually.

Q Under these policies, how are claims administrations handled?

A Normally the employee contacts our office. We give them a claim form. They complete the claim form, send it back to our office. We certify eligibility, check the claim to make sure that everything is in order, make a photocopy of it, and send it to Lincoln National. They pay the claim and take over from there.

Q Lincoln National is the carrier you are using predominently at this time?

A Yes, it is.

Q And you have used other carriers over the past?

A Yes, we have.

Q What is your reimbursement for this?

A We are paid a per capita for each employee.

Q Now, what are the alternatives open to a plan for providing benefits other than purchasing insurance policies?

A They can be uninsured.

Q What does that mean?

A That means that they can pay the claims right out [1-49] of the assets of the trust itself without any insurance company involved whatsoever.

Q Now, what are the advantages and disadvantages of having an insured plan as opposed to an uninsured plan?

A The advantages of an insured plan, in my personal opinion, are the great stability and the experience and the knowledge and know-how that any insurance company brings to the plan. There are times when there is a lot of unemployment. There is a time we have cash flow problems in the plan, and so forth, when the very viability or the very solvency of a plan could be jeopardized if they didn't have insurance. By having an insurance carrier there, and they have the know-how, they have the knowledge, experience. They can process claims.

As a third party payer they are not subject to the political pressures that would be evident if, for instance, my office was personally paying the claims. In other words, union members, trustees, and so forth, could come and put pressure on me and my employees to pay claims that normally should have been paid. That kind of pressure cannot be placed on a big insurance carrier. I, personally, feel that that is a tremendous advantage to the fund to have the insurance carrier there.

[1-50] The only disadvantage I see is the very fact that states can mandate benefits for an insurance carrier, but they cannot mandate benefits for the uninsured. Therefore, if we went uninsured—I do not like the term self-insurance because there is no insurance involved there at all. If they were uninsured, then they could not mandate the benefits, and the unions could control their own plans.

Q You gave an example before with respect to the carpenters, that the actual claims submitted one year was $350,000 greater than the premium, approximately.

A Yes.

Q What would have happened if that plan was uninsured?

A They would have been bankrupt. They could have gone out and borrowed money at high rates of interest, which to me would be self-destructing because they would have to reduce benefits. They would have to pay back that money eventually. They would have to pay interest on that money, and certainly they would have to increase eligibility and reduce benefits, and I feel it would be a disaster.

Q Now, in your industry is employment cyclical?

A It definitely is.

Q Is there any relation to bad weather and the amounts [1-51] available to pay for claims?

A Yes, there very definitely is.

Q Could you describe that?

A Well, obviously in the wintertime, particularly in Maine, New Hampshire, and Vermont the weather is so bad that construction almost comes to a halt. When there is nobody working, no employer contributions are coming in, and the cash flow is down to a trickle. In some of the funds that don't have big reserves at a point in time—and that, incidentally, is when most claims are received in our office. You take, for instance, a man who might have a hernia and he wears a truss for six months out of the year, but then he knows he's going to be laid off for two or three months. He decides to go and have that hernia repaired because that's a good time to do it. Not only would he have his hernia taken care of when he's not working, he'll also collect weekly income replacement during that time, which is an added incentive. So most of our claims come at a time of low employment. That's statistically proved over the years. So consequently you would have all your claims at a time when you had no cash flow, no money to pay the claim. Again, that's disaster.

Q Well, does insurance help alleviate that problem?

[1-52] A Yes, with insurance you pay your insurance for the next six months; and whether you bring in any money or not the claims are going to get paid; and whether the claims exceed the premiums, they are going to get paid.

Q Did the bricklayers have a deficit at some point?

A Yes, they had a $64,000 deficit last year.

Q And by "deficit" do you mean that the amount paid by the insurance company was approximately $64,000 greater than the premiums?

A That's right.

Q How was that resolved?

A At the present time it hasn't been resolved. This year there was an experience refund of $32,000, and there is still a deficit of a little over $30,000, and the bricklayers are presently considering whether or not to

walk away and leave them holding the bag and possibly go uninsured.

Q Now, what would have happened in the past if the bricklayers had not been insured and had run up that deficit?

A They probably would be bankrupt.

THE COURT: We will take the morning recess.

(Recess.)

[1-53] Q Mr. Dawson, are you familiar with the phrase "mandated benefit clause"?

A Yes, I am.

Q What do you understand that phrase to mean?

A I understand it to mean those benefits which have been mandated by law for a plan to have to have as part of their package.

Q Does New Hampshire have a mandated benefit law?

A Yes, it does.

MR. GREENFIELD: Your Honor, we have a copy of that statute here. With the Court's permission, I will hand it up.

THE COURT: Do you have a copy?

MR. MONTGOMERY: Well, we do have a copy, and it certainly is available to us. We don't have a copy with us.

MR. GREENFIELD: I'm not going to go into the particular details of the statute, your Honor. I think we have an extra copy, in any event.

MR. MONTGOMERY: I would certainly like to see it in case I might inquire with respect to the statute. Thank you.

We have no objection.

THE COURT: Is an offer being made of this [1-54] Counsel? Are you making an offer?

MR. GREENFIELD: I will, your Honor, but it's not really evidence in the strict sense. It's a statute.

THE COURT: We'll mark it for identification.

(Copy of statute, above-referred to, marked Exhibit A for Identification.)

MR. GREENFIELD: Your Honor, as I understand it, that is Section 45:18A.

Q Now, is it part of your duties to be generally familiar with the requirements of that statute?

A Yes, it is.

Q Could you give us your understanding of what that statute requires?

A It requires that nervous disorders and mental conditions that may be helped by short-term therapy in the opinion of a psychiatrist, such as a psychologist, must be paid for on the same basis that other medical benefits are paid for to other professionals.

Q Do you understand if there's—that law or any amendment to that law provides anything with respect to pastoral counselors?

A Yes, that law which originally applied to psychiatrists and psychologists now applies to licensed [1-55] pastoral counselors as well.

Q Now, are you at all familiar with a case known as Wadsworth against Whalen?

A Yes, I am.

Q What is the basis of that familiarity?

A I was one of the participants in that case.

Q Now, did the enactment of the New Hampshire mandated Mental and Nervous Benefits Law have any effect on any of the plans you administer?

A Yes, it did.

Q Would you describe those effects?

A In the case of the Northern New England Carpenters, the Carpenters had to make the very hard decision. They felt they could not afford to pay for the benefits required by that statute and still keep all the benefits they had in their own particular plan. The net result was that they increased the eligibility requirements

from 600 to 750 hours every six months and they eliminated all vision and dental care under their package in order to meet the requirements of the state mental health law in New Hampshire.

Q Now, approximately what had they been paying, what percentage had been paid into the fund with respect to visual and dental care?

[1-5C] A Vision and dental care was costing them approximately ten percent of their package.

Q Approximately what would have to be paid into the fund to provide the benefits covered by the New Hampshire mandated benefit law?

A Our insurance consultant estimated they would increase our cost by ten percent.

Q Now, did the enactment of that law have an impact on any of your other funds?

A Yes, it did.

Q Could you describe that?

A Basically it had the same impact on most of the other plans, and it was at that time that many of them went from 600 to 750 or 800 hours. The one that had 400 hours of eligibility went from 400 to 600 hours of eligibility, and there was a very definite—besides a cost, it had an antagonistic result in the plan. The members became antagonistic to me as well as the very fact that they had to have something they didn't want and to give up something they did want. Many of the benefits—most of these funds are in, you might say, a state of flux. They are continually seeking to improve the packages. If they had their way, they would reduce eligibility [1-57] requirements down to a minimum, and they would also increase the maximums on all the coverages. They are continually striving to do this. So there was a period there when they could not only not increase their benefits, as in the case of the Carpenters, they actually had to reduce benefits. Most of the other funds, as I said, increased the rules of eligibility, which, again, is a cost

factor to the members, and it hurts. They were very belligerent and antagonistic and very unhappy about it.

Q Was any unhappiness expressed with respect to the fees charged by psychologists?

A Yes, I had one particular example that stands out in my mind. There were many of them, but this one stood out because the woman was so graphic in her discussion. She came to my office and asked to see me personally, and she said she had a real gripe. She wanted to know why we had, through Lincoln National, had paid $35 for a visit from a psychiatrist, and I said because that's the bill that was submitted to the insurance company. I had gone to the file—as I told you previously, I kept photostatic copies of all bills and all claims—and I showed her the actual bill from the [1-58] psychiatrist of $35 per visit. She was very, very incensed. She said she had been going to this Manchester Mental Health Center for quite some period of time, and prior to this they had been charging—and she was receiving group therapy, not individual treatment, group therapy—she said she had been charged $6 for each visit up until the time that the mental health law was passed. At that time each individual, apparently, judging by her bill, was suddenly charged $35 for each participant in group therapy, and she was highly incensed about it and felt she was cheated.

Q Did the statute have any additional effect upon the Bricklayers Fund?

A Yes, the Bricklayers Fund went to a position where they were technically financially insolvent. I believe at that particular time they dropped down to about $20,000 total assets, which doesn't represent even six months coverage. It might be well to explain a little bit more in detail exactly how this works. As I stated previously, an individual has to work either 600 or 750 hours in a six month period, and there is a two month lag between the time that the man has completed his eligibility [1-59] requirements and when the insurance actually

goes into effect. Because we, in fact, have to get all the employers' reports into our office, put them on computer, tabulate them, send out notices to the employees telling them who is covered and who isn't covered, and so forth. So at any one time there should be eight months of contributions, the six months that have come in plus the two months lag. So at any time there should be eight months reserves just to break even. At that time, as I say, the Bricklayers had about $21,000 in reserves where they should have had at least $60,000 in reserve just to break even.

Q How does this relate to the New Hampshire mandated benefit law?

A We believe that it was the additional expense of that law that caused the fund to go downhill financially.

Q What, if anything, did the Bricklayers do with respect to this problem?

A What they actually did was they went to their employers and asked the employers—because this was in between negotiations they could not negotiate a larger contribution, so what they did was ask the [1-60] employers to take an additional either ten or fifteen cents—at the present time I'm not sure which one—an additional contribution out of their pay envelope and reduce their pay by that amount and put that money into the fund to keep it solvent.

Q Now, in your opinion would the benefit packages that your unions now have be any different today if there were no New Hampshire mandated benefit statute?

A Absolutely.

Q How would they be different?

A Programs that they wanted, some of the programs don't yet have vision and dental. They would like to have them. Others, for instance—

MR. MONTGOMERY: Objection, your Honor.

THE COURT: I'm going to take it, but it may be subject to be stricken. I'll hear the answer. You may go on.

A Some of the members, as I previously explained to you, the plumbers, would have liked $1,000 maximum on their dental, $125 on vision. Most of the plans that have vision, for instance, now would like, at least, because it's not practical to say that you can get a pair of glasses for $75. It's just not [1-61] practical anymore, and that's the type of benefit they would like to have. But by taking money and spending it for mental health care, that precludes at this time the benefits that they would really like to have. They would like to have—most of them have a surgery schedule of the maximum $500. Today I submit a surgery maximum of $500 is no more practical, but there isn't any of them that have a higher schedule than $500. Some of them have board and room, hospital board and room as low as $20 a day, certainly not practical. Obviously, they would like that better, but they can't afford it at this time.

Q Now, as you mentioned it, does the New Hampshire mandated statute apply to employees who reside and work in New Hampshire?

A Yes, it does.

Q Some of the employees in your unions work in all three states; is that correct?

A Yes, they do.

Q And some of them change residences as a function of where they are working?

A Yes, they do.

Q And some of them on occasion, because of the itinerant [1-62] nature of their work and the fact that they might have families, may at one point in time have more than one residence?

A Yes, they do.

Q Or they may be residing, either for that reason or for personal reasons, apart from their wives and children?

A Yes.

Q Now, if you were to administer the fund so as to apply the New Hampshire benefits only to employees who

are residing and working in New Hampshire, would that create any sort of administrative problem?

A It certainly would.

Q Could you describe those problems?

A Yes, as I previously stated—let's use the Carpenters as a good example. The Carpenters, as I believe, are contributing 73 cents an hour into their plan. Now, if they contribute—if John Smith is contributing 73 cents an hour and John Brown is contributing 73 cents an hour and one of them lives in Maine and one lives in New Hampshire, yet they are both contributing to the same plan and their employers are paying the same cents per hour on their behalf and yet one has a coverage that the other one doesn't [1-63] have, and even worse than that, if we were to carry it to its logical conclusion, because the man living in Maine didn't have to have the New Hampshire benefits, he could have greater benefits in another area to compensate for it, you would have actual chaos there, the fact that two people working together at the same bench causes tremendous resentment and real hardship.

Q In administering ERISA plans, is there something known as a plan document?

A Yes, there is.

Q What is a plan document?

A ERISA requires what we call a summary plan description and a plan description to be delivered to every participant. In fact, it is called the plan booklet or the plan document, and it describes in detail, and the law requires it be in language that the individual can understand. That describes the plan and all its benefits.

Q Now, if you were to apply the New Hampshire statute so as to only provide benefits to employees working in and residing in New Hampshire, would that have any effect upon plan documents?

A Yes, because we would have to produce a plan document for each particular state and what benefits

that [1-64] particular state had. Instead of one plan document which would be given to everybody regardless of where he resided, you would have to have a different one for each individual situation.

Q Now, these various things that you have been testifying about for the past few moments, would they have an effect on the administrative costs?

A They have a tremendous impact on cost because just printing new documents is a very expensive procedure.

Q Now, do you, in fact, provide the New Hampshire mandated benefits only to employees who work and reside in New Hampshire?

A No, the trustees, in examining the situation, felt that the cost impact of doing exactly that in providing separate booklets for everybody, and so forth, would be greater than actually providing the uniform benefits for everybody, and they felt that the uniform benefits were so important that they spent the extra money to provide the same benefits for everyone regardless of where they lived and worked.

Q Are you aware of the existence of other mandated mental benefit laws besides New Hampshire?

A Yes, other states have various mandated benefits. [1-65] Q And are you aware of the existence of mandated laws in areas other than mental health?

A Yes, some states require payments for chiropractors, osteopaths, chiropodists, various other benefits.

Q As a professional administrator, are these mandated laws of concern to you?

A They certainly are.

Q And are they of concern to other professional administrators?

A Certainly.

Q What is the reason for that concern?

A Well, in the first place, it goes to the very basics of creating these plans. Plans such as the Carpenters were created in order that you might have uniform

benefits for people who have to work in three different states. At the present time in the Seabrook Power plant in Seabrook, New Hampshire, we have itinerant workers from almost every state in the union. The very fact that all these workers have to work in all these different places was what created such as the Northern New England Carpenters, so the carpenters in Maine, New Hampshire, and Vermont could all work together in the area harmoniously, have one set of plans that would satisfy everybody, [1-68] and reduce administration costs. That's one of the real things of having a plan such as the Northern New England Carpenters. Now, if you're going to create havoc, in my opinion, by having different mandated benefits in all three states, you are going to increase tremendously the administrative costs. You are going to destroy the continuity or the regularity of having one set of benefits for everybody, and it's just chaos for administrators, and we are very concerned about it.

Q Now, in actual practice in your experience, does the New Hampshire mandated benefit law affect plans as such?

A It very definitely does.

Q Could you explain, without repeating anything I just said, how this is so?

A Well, aside from what I already said, it makes them make a very hard decision. Either we are going to have to meet the costs of all these mandated benefits, or we are going to go uninsured, which is the only way to go out of it. There's the gist of the whole thing. Many of them are small plans that cannot afford to go uninsured. They don't have the cash flow. They don't have the resources, and they can't [1-67] afford the benefits. It's a Catch 22 situation. They can't afford the benefits, and they can't afford to avoid them by going uninsured.

Q Do you have any opinion as to what the—aside from the administrative costs—as to what simply the

benefit cost of the New Hampshire mandated statute has been?

A Well, the only way that I have to base my opinion on is the experience of Blue Cross-Blue Shield. Some of our plans previously had Blue Cross-Blue Shield. We are very familiar with their situation, and we know for a fact because it's public knowledge that they had asked Commissioner Whalen for, I believe, a 20 percent rate increase—

THE COURT: 20 or 27?

THE WITNESS: 27 percent rate increase.

A It was rejected by Mr. Whalen. That plan up there is a Vermont, New Hampshire plan. It covers both Vermont and New Hampshire. It's one plan. An investigation proved that Vermont did not need that rate increase. Further investigation proved that it was the opinion of Vermont that the reason they didn't have to have the plan was because they didn't have mandated benefits, where New Hampshire does. [1-68] After considerable discussion between the insurance commissioners of both states it was decided that because Manchester had mandated benefits, which was increasing the costs tremendously—Vermont didn't need those—Vermont would be better off by itself. And as of November 1, according to press releases, Vermont will be separated from New Hampshire as far as their financial structure is concerned. They will have their own rate structure, but they will use the administrative services of New Hampshire, but they will not be involved in the rates or the financial resources of the New Hampshire plan. So they are separating because of mandated benefits.

Q Do you have an opinion as to what the impact on plans would be if Wadsworth is followed and the number of state mandated benefit statutes increases?

A Some of the plans could go bankrupt.

Q Why do you say that?

A Simply because they cannot afford the benefits, and they cannot afford to go uninsured either. If they try to

go uninsured, I think many of them will collapse. They are too small to handle it. They don't have the reserves.

Q Now, as an administrator, have you considered ways [1-69] to reduce or avoid the burdens imposed by mandated benefit statutes?

A Yes, we considered going uninsured.

Q Would you have any reason to go uninsured other than to avoid the mandated benefits—benefits mandated by such statutes?

A No.

Q What alternatives do the small plans have on the mandated benefit statutes?

A I don't think they have any alternatives.

Q With respect to the functions that they play, is the there any difference between an insured plan and a non-insured plan?

A No, there isn't.

Q Based on your experience, can you conceive of any possible reason for treating the two types of plans differently with respect to the application of state mandated benefit laws?

A No, I cannot.

* * * *

[1-72]

CROSS-EXAMINATION
BY MR. MONTGOMERY:

Q Mr. Dawson, are any of the eight plans that you administer insured either through Metropolitan or Travelers?

A No.

Q With respect to the New Hampshire statute that you discussed on direct examination, I think that you testified that it requires that benefits be provided for mental or nervous conditions to the same extent as for other illnesses; is that correct?

A Correct.

Q Is there a limit on the recovery of a claimant under this statute?

A I believe it's $10,000.

Q Are you familiar with the Massachusetts statute which is the subject of this proceeding?

A No, I'm not.

Q With respect to the coverage that's afforded on mental and nervous conditions through the plans that you do administer, are the coverages for mental and [1-73] nervous conditions standard for each plan?

A Yes, there are.

Q How many insurance companies do you use through the plans?

A Just one.

Q And is there a standard co-insurance provision that applies to the mental and nervous condition coverage?

A Under major medical?

Q Yes.

A Yes, 20 percent.

Q And is that same 20 percent co-insurance provision applied to all other major medical benefits?

A Yes.

Q Is there any deductible on your plans?

A Yes.

Q What's the deductible?

A $50 as far as the Carpenters are concerned. The Masons are $100.

Q On direct examination you testified with respect to your experience in meetings with union representatives in New Hampshire and Maine and Vermont, and that your role at these meetings has been to inform them with respect to the types of insurance coverage that is available; is that correct?

[1-74] A Yes.

Q And presumably you do inform them with respect to the mandated benefits that restrict the choices that they might make?

A Yes, I do.

Q Now, in addition to various statutes which require payments to certain types of practitioners, isn't it true that there are other types of mandated benefits?

A Such as?

Q For instance—and you would be more familiar than I—does New Hampshire, Maine, or Vermont mandate conversion benefits?

A Yes, they do.

Q Could you please define your understanding of conversion benefits?

A If an individual is covered by one of our policies and he loses his eligibility, we have to provide him with the opportunity to convert that policy to an individual policy within a certain given number of days after his regular policy expires.

Q And are the conversion benefit statutes in New Hampshire, Maine, and Vermont identical?

A I don't believe they are.

[1-75] Q They do differ to some extent?

A That's right.

Q I believe you testified you played a role in the case of Wadsworth versus Whalen. You said you were a participant. In fact, you were a plaintiff, one of the plaintiffs in that case?

A Yes, I was.

Q Have you ever been a plaintiff in any other case challenging a mandated benefit statute?

A No, I have not.

Q So that you haven't challenged any of these other types of mandated benefit statutes?

A No, I haven't.

Q In addition to conversion benefits, were there any other examples that you can think of that require coverages in the states of New Hampshire and Maine and Vermont?

A I don't think of any offhand.

Q How about waiting periods? Are there any requirements on waiting periods?

A Actually none of those apply to our plans because a participant becomes covered immediately as soon as he's got the required number of hours in. So it doesn't impact on our plans at all.

[1-76] Q Is your answer, by implication, yes, there are statutes in those states?

A Yes, there are.

Q And do you know specifically what those statutes say?

A No, I don't.

Q But the benefits of your plans are more liberal than the required mandated benefits?

A Yes, they are.

Q Now, do any of the plans that you administer provide benefits to employees who are residents of the Commonwealth of Masachusetts?

A It's very possible, very possible. I'm sure there are. Let me explain. I'm not positive how many residents of Massachusetts there are because as I previously explained the itinerant workers oftentimes move into an area and stay there. Construction workers will hire a trailer between them.

Q Let me restate my question. Are any of the employers who contribute to the plans that you administer residents of the Commonwealth of Massachusetts?

A Yes, they are.

Q Could you identify the names of some of those employers?

A Volpe, Grande Brothers, to name a couple.

[1-77] Q Now, do those employers contribute to your plan with respect to services provided by members of the plan in Massachusetts?

A No.

Q So only the—the contributions only apply to work that is performed in the three states, New Hampshire, Maine, and Vermont?

A That's right.

Q So the administration of your plan is confined exclusively to those three states?

A Yes, it is.

Q Returning again to your role in collective bargaining. I think you have sometimes in your direct examination referred to negotiated plans.

A Yes.

Q Isn't it true, Mr. Dawson, that some plans negotiate the particular benefit while other plans negotiate the level of contribution by employers to the plan?

A I can only speak for the plans that I administer and in each case while the contract that is finally negotiated specifies a cents per hour, that cents per hour is determined by the cost of the benefit that the individuals wanted. So an individual might say that "I want vision and dental now," and I tell [1-78] them it's going to cost ten cents an hour to get it. The contract actually says ten cents an hour, but that ten cents an hour is the dime to pay for the vision and dental that they just negotiated.

Q Do you agree that what the employer has agreed to contribute is a level, a particular amount per hour, for the services, in connection with the services of a particular employee?

A Yes, he agrees to cents per hour based on whatever they agree to furnish.

Q Therefore, the collective bargaining agreement itself contains nothing about particular benefits?

A That is correct.

Q But it's been your information provided to the union with respect to available benefits that has determined the level that they have demanded from the employer?

A That's correct.

* * * *

[1-81] Q Have you ever administered an uninsured plan?

A No, I haven't.

Q Would it be fair to say that if you ever did administer such a plan that it would be likely that such a plan would contain some saving provision that would prohibit or avoid any payment over claims—I mean, any claim payments over the level of contributions to the plan?

A It's possible.

Q Well, I mean, obviously it seems to me that you wouldn't have the money to pay claims in excess of payments, correct?

A I would recommend that to the trustees.

Q What do you mean by recommend to the trustees? What process—if you receive claims in excess of receipts or pay-ins to the plan, what procedure would you then follow?

A I would go to the trustees—if it was uninsured?

[1-82] Q Uninsured.

A I would go to the trustees and tell them that we were in a deficit position, we couldn't pay our bills, and they would make a decision whether they wanted to go out and borrow money or declare themselves bankrupt.

Q You also testified with respect to a cyclical experience in your practice and your business in New Hampshire, and I was a little bit puzzled by your testimony. You said that an uninsured plan would have difficulty paying claims during the winter months because you have a reduced cash flow. Is that a fair summary?

A That's correct.

Q I'm a little puzzled by that. If you were going to run a self-insured plan, wouldn't you establish provisions through reserves, and wouldn't you be adequately capitalized to avoid that particular problem?

A I would certainly recommend that the trustees do that, but I have no guarantee that they would do that. In fact, experience has proved that in the case of the carpenters or the bricklayers, specifically, they had huge deficits that would have, had they not [1-83] had insurance and the insurance carried them for the deficits, they

would have been bankrupt. So in point of actual experience, the trustees don't exercise those constraints.

Q Well, of course, because you use the insurance mechanism the trustees don't have to exercise those constraints; isn't that true?

A That's right, but that's the only thing I have to go by.

Q So you really have no experience that would shed any light on what would occur if the plans were self-insured?

A Only the experience of what has happened while they were insured.

Q But presumably if they were self-insured, at least by your testimony, the benefits would differ. Isn't that a fair assumption?

A It could be.

Q And if the benefits differed, presumably the costs would differ? Is that also a fair assumption?

A That's correct.

Q Now, previous to the enactment of the New Hampshire mandated benefit law, did the plans that you administer provide any benefits for treatment of mental or [1-84] nervous conditions?

A Yes, they did.

Q And have you done or had any studies performed or compiled any data that would reveal the difference in expenditures under the plans as they existed prior to the enactment of that statute and then subsequent to the enactment of the statute, with respect to that particular benefit?

A There were no actual studies done other than to compare the fact of what the limits were before and what they were afterwards.

Q Now, in your direct testimony you indicated that the cost—that you were estimating the cost impact of this statute from Blue Cross-Blue Shield?

A That's right.

Q Can I take it from your answer that you don't have any specific cost data from your experience with Lincoln National?

A Only as I said the increases in what we were providing as a payment to psychiatrists and psychologists and what the law mandated we had to pay them and what we actually did.

Q What do you mean by that?

A We were paying $10 a visit. That was the maximum. [1-85] Our policy provided we would not pay more than $10 a visit. By law we began paying $35 to $50 a visit.

Q With no limit on the amount that you have to pay up to $10,000?

A Yes, up to $10,000, right.

Q I'm a little puzzled. You mean you don't have information from Lincoln National of your experience of the total payout to psychologists and psychiatrists?

A They do not break it down because nervous conditions can be—let me give you a typical example. A woman at the time of menopause has a lot of nervous disorders. Many of the claims originate at that period of time. Is the root cause physical condition other than mental or nervous? Her doctor might indicate that it was other than mental, and yet she is being treated by a psychiatrist. So the claims data that we get does not indicate that. Therefore, we cannot, the way we handle claims, actually put our finger on that. So our figures came from our insurance consultant who gave us the estimates of what it would cost us.

Q So that to sum it up, there isn't from your personal experience or the experience of the plans you [1-86] administer any data base that's available to draw any conclusions about the impact of the statute?

MR. GREENFIELD: Objection. I don't think he's fairly summarized what his testimony is.

MR. MONTGOMERY: I asked the witness whether I fairly summarized the testimony.

A Well, as I said, the difference is $10 a visit as opposed to $35 to $50 a visit. That's some impact in my opinion.

Q But there is no data base?

A That's right.

* * * *

[1-86] Q Mr. Dawson, with respect to your testimony on direct concerning the cyclical nature of the claims experience in New Hampshire, I believe that just before the lunch break I asked you to explain your testimony that because of cash flow problems it would be difficult in an uninsured plan to make payments in light of this cyclical claims experience?

A Yes, I was referring to those funds who did not have large enough reserves to carry them over in a time of cash flow problems.

Q But, in general most plans, in order to function, have to, like insurance companies, maintain some level of reserves in order to function at all, correct?

A They should, but unfortunately they do not.

Q You mean the plans or the insurance companies?

A The plans do not maintain the reserves they should.

Q I think you previously testified that you didn't have any experience with self-insured plans?

A That's correct. But what I'm saying is that those insured plans just maintain enough money to pay the [1-89] premium when it comes due. They don't have any reserves. As I thought I explained, if an individual has worked six months, he has prepaid his insurance. And there is a two-month lag, so an insurance company to just break even has to have eight months in reserves even when they are insured, and many of them don't have that amount of money.

Q Mr. Dawson, correct me if I'm wrong, but I think you testified on direct with respect to the importance to cover members of plans, of the level of benefits provided, for instance, for surgery?

A Yes.

Q I think you specifically mentioned surgery, and that the general level is $500 per procedure in the plans you administer, right?

A Yes, I did. That's correct.

Q And of course the level of benefit coverage would also be important with respect to the coverage of mental and nervous conditions, right?

A Yes, it would.

Q And you also agree, wouldn't you, that the level of coverage is an important, if not the crucial—

THE COURT: Level of coverage or benefit?

MR. MONTGOMERY: Level of benefits; excuse me. [1-90] Q —is a crucial determinant of the total cost of the plan?

A Yes, it is.

Q And would you agree that the difference—that the cost of New Hampshire plans would be substantially affected if they were reduced, if the New Hampshire legislature were to reduce the total available benefit for mental health coverage from, let's say, a hypothetical $10,000 to $5,000?

A Yes, that would help.

Q That would have an effect?

A Yes, it would.

Q Now, if the New Hampshire legislature would reduce the total benefit from $10,000 to $500 per year, would that also have an effect?

A Yes, it would.

Q And would you believe that that effect would be substantial?

A Yes, I do.

* * * *

[1-92] Are you familiar, Mr. Dawson, with the concept of what is called in health insurance circles "utilization controls"?

A Yes, I am.

Q Could you explain what utilization controls in general are?

A Well, basically it's an attempt to control the use of any particular coverage.

Q Can you give examples of utilization controls in any particular area of health insurance?

A I don't think so.

Q Are you familiar, for instance, with peer review of procedures?

A Yes, I am.

Q Could you explain what peer review procedures are?

A Well, what happens is that if—well, for instance, in the case of our dental program, a dental bill is submitted. If either the fund office or the employee questions it, that bill is submitted to a group of dentists who are the peers of those charging the thing, and they review the thing to see whether [1-93] or not it's reasonable, and they can knock the bill down , if necessary.

Q Are there any particular utilization control procedures that have implemented by any of the plans that you administer?

A Yes, the vision and dental both have peer review boards.

Q Are there any other utilization controls?

A The dentists have to file a fee profile showing exactly what their charges will be, and every claim is compared to the fee profile when the dentist makes a claim.

Q With respect to benefits for mental and nervous conditions, are there any utilization controls that have been implemented by any of the plans?

A Not to my knowledge.

* * * *

[1-95] Q Are you aware of any plans, employee plans, in the State of Vermont that are uninsured?

A I am not aware of any.

Q Are you aware of any in the State of Maine that are uninsured?

A I am not aware of any.

* * * *

REDIRECT EXAMINATION
BY MR. GREENFIELD:

[1-97] Q Now, when negotiations take place between the unions that you represent and the employers are specific benefits discussed?

A Very definitely there are.

Q And are the costs of specific benefits discussed?

[1-98] A Yes, they are.

Q And is there a give and take and tradeoffs with respect to specific benefits?

A Yes, there is.

Q And are there compromises with respect to specific benefits?

A Yes, there is.

Q Now, if an insured plan incurs a deficit of $100,000, for example, and does not walk away from the insurer, is that deficit recovered in the subsequent year?

A No.

Q Over how long a period is it recovering?

A It's negotiated usually three to five years.

Q What happened with respect to the Carpenters when they had a deficit of $325,000?

A They negotiated with Lincoln National that any refund in subsequent years would go 50 percent back to the fund and 50 percent to write off the deficit until it was paid.

Q And how long did it take to pay off what deficit?

A I believe it took about three or four years.

* * * *

TESTIMONY OF JOHN D. MORRIS

DIRECT EXAMINATION
BY MR. GREENFIELD:

[1-99] Q What is your name?

A John D. Morris.

Q And your home address?

A 93 Tersama Drive, Easton, Connecticut.

Q And what is your present employment?

A I work for General Electric Company. My title is [1-100] consultant, insurance benefits and payroll practices.

Q And where is your place of employment?

A Fairfield, Connecticut.

Q Could you describe your responsibilities to General Electric?

A My job in insurance, basically, involves the financial aspects of our insured plans, which would involve negotiations with our carriers on rates, contract amendments, plan changes, and the like.

Q In the course of your duties do you conduct negotiations with those insurers who handle General Electric's business?

A I do.

Q About what subjects do you negotiate?

A Premium rates, financial arrangements, implementation of benefit changes, and the like.

Q Now, within the General Electric hierarchy where do you fit in with respect to responsibilities for insurance benefits?

A With an associate in employee relations, the two of us do the job.

Q Are you the two most senior people in that area?

A Yes.

Q Could you trace your educational background?

[1-101] A I attended Cornell University. I have a bachelor's degree in economics and a master's degree in business administration with a concentration in accounting. I received the latter degree in 1949.

Q Are you a member of any professional societies or similar organization?

A Yes.

Q And what are those memberships?

A Well, I am a member of the Financial Executives Institute, Committee on Employee Benefits, and a subcommittee on insured benefits.

Q Have you participated in the Business Round Table?

A Yes, I have.

Q Would you describe that participation?

A The Business Round Table created a committee on privacy in the workplace for employees. I served on that committee. We held a series of seminars around the country last year which were attended by in excess of 600 executives from Business Round Table and other companies.

Q Have you ever given testimony before any federal commission?

A Yes, I have.

Q Would you describe that?

[1-102] A I testified before the Federal Privacy Study Commission in connection with confidentiality of employee records. I subsequently testified before a Department of Labor hearing on workplace privacy.

Q Now, does General Electric provide health benefits for its employees?

A Yes.

Q Does it have a group of benefit plans?

A Yes, it does.

Q Approximately how many plans does General Electric have?

A I expect we probably have 20 plans.

Q And do these include something known as the General Electric Insurance Plan?

A Yes, it does.

Q And from where is that plan administered?

A It is administered in Fairfield, Connecticut. Under ERISA, General Electric is the plan administrator.

MR. GREENFIELD: Your Honor, I would like to put into evidence two documents that have been previously marked. Exhibit 1 is a publication entitled "General Electric Employee Benefit Plan Document." Exhibit 2 is a publication entitled "General Electric Employee Benefits, Summary Plan [1-103] Description," and I move them into evidence.

THE COURT: May I take a look at them, please? I assume these are without objection?

MR. MONTGOMERY: No objection.

(Two General Electric documents, above-referred to, marked Exhibit Nos. 1 and 2.)

Q Could you explain what Exhibits 1 and 2 are?

A Exhibit 1 is a document that contains the official text of specified benefit plans. Beginning on page 1 and continuing through page 25 is the General Electric insurance plan, the official text and the supplements. Exhibit 2 is a summary plan description of exactly the same plans contained in Exhibit 1. The summary plan descriptions are required by ERISA. They are supposed to contain a statement of the plan couched in language understandable by the ordinary person. We are required by ERISA to provide the summary plan description, but we historically have and continue to provide employees with the official text of the plan.

Q Now, both Exhibit 1 and Exhibit 2 say on their covers that they are for non-exempt salary employees. Do other employees receive—do other regular employees receive the same benefits as are described on [1-104] Exhibits 1 and 2?

A We have three categories of employees, exempt employees—this is under the Wage, Hour and Fair Labor Standards Act—non-exempt salary employees, and hourly employees. As far as the General Electric insurance plan is concerned they are identical in all three plan booklets.

Q By "identical" do you mean that they receive the same health insurance benefits?

A Exactly.

Q Does the president receive the same benefits as a sweeper does?

A Absolutely, the Chairman of the Board has exactly the same health benefits as the lowest paid hourly employee.

Q And do the health benefits depends upon what state you are in?

A No, we have uniform benefits in the health area.

Q Now, how many covered employees are there under the insurance plan?

A At last count we had 274,000 employees plus 8,000 in our Credit Corporation, which is 282,000. In addition, we had about 13,000 employees who are not actively at work, absent because of illness, layoff, [1-105] leave of absence, whose coverage was continued under the plan. In addition, we have some 17,000 pensioners under age 65 who continue to have the same health benefits as provided in the booklet. So altogether that's about 312,000 employees and pensioners.

Q Now, does the plan provide benefits for dependent coverage?

A Employees covered by the plan may enroll for dependent coverage.

Q How is that financed?

A They pay up to a maximum of $100 a year for dependent coverage. If I may add, the coverage is exactly the same as the coverage as it applies to each employee.

Q How many dependents are covered?

A Let me try it the other way, please. About 70 percent of our employees and pensioners have dependent coverage. So that means 220,000 employees have dependent coverage. Our insurance company's actuaries advise us that there are probably two and a half dependents per dependent unit. So that comes up to 600,000 or 700,000 dependents.

Q Now, does—and so all together about a million people are covered by the plan?

A About a million people; that's correct.

[1-106] Q Does General Electric engage in collective bargaining negotiation with any unions?

A Yes.

Q Is there any relationship between those negotiations and the benefits specified in Exhibits 1 and 2?

A There is.

Q Would you describe that realtionship?

A Well, we enter into collective bargaining, and the result is that we end up with benefit plans that have been collectively bargained.

Q Are specific benefits bargained?

A Yes.

Q Do you play any role in the collective bargaining process?

A I do.

Q Could you describe that role?

A My principal role is a support role in helping to prepare cost estimates and other data required for the negotiations, subsequently reducing these, with the cooperation of the insurance company, to plan language and eventually into summary plan description language.

Q Now, in performing these duties do you conduct any studies or do any surveys?

[1-107] A Our company does, yes.

Q Could you describe them?

A There are several kinds. First, we have our employee relation staff visit plant locations where there are not collective bargained units and discuss with employees and management what the employees feel are their needs in the benefit area. We also hire outside consulting firms to make surveys of our employees and pensioners to obtain information of their interest in terms of benefits. We also conduct surveys of our peer companies as well as the companies that are in competitive areas to determine benefits.

Q And certain priorities are determined as to what the workers want and what they don't want?

A That is correct.

Q Does the union do anything of a similar nature?

A Yes.

Q Would you describe that?

A The exact process I don't know. However, they do talk to their workers, and then periodically in their plant newspapers and other organs will publish the results of their discussions with their members in terms of what the members of the collective bargaining [1-108] unit want.

Q And that is again in terms of priorities?

A Yes.

Q Do you attend some collective bargaining sessions?

A Yes.

MR. GREENFIELD: Now, I would like to offer this into evidence as Exhibit 3. The Commonwealth has consented to its admission. This is a document which the witness will further describe which is entitled "Health Insurance," and it bears in the upper left-hand corner IUE-AFL-CIO-CLC, May 16, 1979.

(Document, above-referred to, marked Exhibit No. 3.)

Q Could you tell the Court what Exhibit 3 is?

A Exhibit 3 is a list of demands in the health insurance area that was presented by the union during bargaining in New York on the date shown.

Q Which union?

A The IUE-AFL-CIO.

Q What role do they play in the bargaining with respect to benefits?

A We bargain nationally with the IUE, and this was the demand they presented. However, we have something called coalition bargaining. What this is is that [1-109] the IUE officially sits at the table, but immediately behind them are representatives of other unions that are in the AFL-CIO, such as the IBEW and the like. So they are present at the table, although technically we do not bargain nationally with the IAM, the IBEW, steel workers, and the auto workers.

Q Now, did you receive a copy of Exhibit 3 in or about May of 1969?

A I did.

Q And what did you do with it?

A I carefully reviewed it, sir, to see which of the items—what was on the list and how many of these I had already prepared cost estimates for. For those that I had not prepared cost estimates, I immediately did so.

Q And did Exhibit 3 play any role during the collective bargaining negotiations?

A It did.

Q Would you describe that role?

A Well, each of the demands was, of course, evaluated and presumably discussed at the table. Some of them did, in fact, were, in fact, included in the settlement agreement. Others were not.

Q Well, why don't you go through items one to five on [1-110] Exhibit 3 and state how they were resolved during the collective bargaining negotiations?

A Yes, sir. Item one, which was 100 percent payment of medical expenses after an employee was out of pocket $1,000 for the employee and family, was, in fact, included in the final settlement and appears in our benefit booklet. Item two, which states eliminate major medical maximum amount—I'll take these one at a time, if I may. Prior to the negotiations we had a lifetime maximum of $250,000 per covered individual. In the negotiation this was incraesed to $350,000. So we didn't eliminate it, but we did increase it to $350,000. Cover all expenses including surgical centers we did include in the contract settlement coverage for ambulatory surgical centers. Nursing homes is the next item. That's sort of an undefined term, but in the contract you will see that we provided for extended care facilities for up to a maximum of 120 days. Recovery facilities, I think we had already covered those in the sense that recovery rooms and the like are in a hospital. On replacement of necessary or required prosthetic appliances, this did not appear in the final settlement.

[1-111] Q That item was rejected then?

A Yes. Well, it didn't appear, so it didn't get through, right.

On item three, relating to mental and nervous disorders to be paid the same as any illness, including alcohol and drug rehabilitation treatment, well, in 1976 we had included in the settlement as the result of a demand coverage for licensed detoxification centers. With respect to the last item, treatment by a licensed social worker, it is not in the final settlement.

Q That was considered and rejected?

A That is correct. Item four was to reduce the family deductible to $100. Prior to negotiations it was $125, and no change was made in that item. On item five, provide complete company payment for insurance for employees and dependents and retirees and dependents for Medicare, Part B. Employee insurance is non-contributory. Insurance for dependents, as I indicated earlier, is $100 a year, and those two were left unchanged. With respect to retirees and Medicare, we did not provide a benefit. However, for employees working past age 65 who are enrolled for Medicare, Part B, the company does reimburse them for the [1-112] Medicare B premium.

MR. GREENFIELD: I would like to offer into evidence without the objection of the Commonwealth Exhibit 4—

MR. MONTGOMERY: No objection.

MR. GREENFIELD:—which is the index to the 1979 settlement agreement between General Electric Company and the International Union of Electrical Radio and Machine Workers, AFL-CIO. Attached to that is Part Two, which is the pension and insurance agreement between General Electric and the International Union of Electrical Radio and Machine Workers.

THE COURT: May I see it.

(Document, above-referred to, marked Exhibit No. 4.)

Q Could you explain to the Court what Exhibit 4 is?

A Yes, Exhibit 4 of the index is actually a summary of the actual signed contract between General Electric and the IUE. As you can see, particularly looking down into the area of Index Tab B, Part Two, there is a separate pension and insurance agreement, and appended to that separate insurance and pension agreement are the texts of the benefit plans as negotiated.

[1-113] Q Would you refer to page 2, which is, in fact, the fourth page of this exhibit, page 2 of the agreement itself, and would you just read in the record the Section 2B?

A Section 2B: "Subject to the approval of the company's Board of Directors and subject to provisions of this Section 2 and Section 1 of Title 2 hereof, the company, the union, and the locals hereby agree that the benefits outlined in the July, 1979, insurance plan shall be made available to the employees in place of the April, 1979, insurance plan as of July 1, 1979."

MR. GREENFIELD: Now, I'd like to move into evidence without objection from the Commonwealth Exhibit 5.

(Document, above-referred to, marked Exhibit No. 5.)

Q Could you tell the Court what Exhibit 5 is?

A Exhibit 5 is, looking back to the index on Exhibit 4, is Tab F, Exhibit D, which would be the General Electric Insurance plan that actually is incorporated in the union settlement agreement.

Q That's the one referred to in the paragraph you just read?

[1-114] A That is correct, and what it is is taking the plan as it was and showing the changes that were made as the result of the negotiations. These are marked with sort of a black tape on the edge of the page.

Q Is it fair to say, then, with respect to Exhibit 5, that where information is typed in as opposed to being printed, that that is what was agreed to during collective bargaining negotiations?

A Yes.

* * * *

[1-120] Q Now, the benefits that are set forth in Exhibit 5, are they the same in every local pay unit?

A They are.

[1-121] Q And are they the same throughout the country?

A Medical benefits are the same throughout the country.

Q And they apply to both union and non-union employees?

A That is correct.

Q What is your reason for doing it in this way?

A Well, we have a long history of uniform benefits in this area. Starting back in 1920 we had group insurance. In the early '50s we got into medical insurance on a nationwide basis for our employees, in 1955, for dependents. But they have been uniform benefits in the medical area since square one.

Q What are your reasons for seeking uniformity?

A Well, there are several reasons. From a cost point of view, it is much more efficient to have one benefit structure. It costs less money to administer. It certainly is much easier to communicate if you have only one plan to communicate. It seems to work very well in our collective bargaining situation. Our unions seem to be satisfied to have one benefit structure that applies to all unions as well without having variations, and certainly from overall employee relations point of view there are not these concerns that employee A has benefit structure A and employee B has a different benefit structure. So it's just [1-122] been the way we have operated and found it to work very well. Uniformity has been, I think, very important in our structure.

Q Is there any relationship between the size of the benefit package and administrative costs?

A Would you repeat that, please?

Q Well, is there any relationship between the amount of benefits given by General Electric and the cost of administering benefit programs?

A Well, we have one benefit structure, and we incur the administrative cost to handle that particular structure, whereas if we had ten structures, it would be more difficult administratively, and it would cost more to administer.

Q And would that affect the amount of benefits

A Well, I think it has to, yes.

Q Could you explain why?

A Well, I believe there is total compensation that is going to be paid to an employee. It's going to be a mixture of benefits; it's going to be a mixture of pay. If you increase the administrative costs, then there is going to be something less for something else in a future time.

THE COURT: I just didn't get that, I'm sorry [1-123] to interrupt you. I didn't quite catch your explanation. Would you go through that again?

THE WITNESS: I would be glad to, your Honor. I'm starting on the assumption or the belief that there is a compensation package total which is worth some dollar amount. It's usually a mixture of benefits, the cost of benefits plus the direct compensation. Now, if for some reason the cost of the benefits is increased because of administrative costs that go up or you do something else, then there is less for something else. Now you may be struck until the next negotiations, but you would take that into account in doing future increases.

Q Is it fair to say that there is something like a finite piece of pie?

A Yes.

Q And the more you spend on administrative the less there is for something else?

A Yes.

Q And the more you spend for one benefit the less there is for another benefit?

A Yes.

* * * *

[1-132] Q Mr. Morris, before the recess you were giving some of your reasons for recommending local pay. Are there any other factors that led you to make that recommendation?

A Well, yes.

Q What were they?

[1-133] A Well, we had a uniform benefit system, and it became very logical to do this with that uniform system in place.

Q Now, did management agree with your view of the merits of the local pay system?

A Yes, they did.

Q And it was your recommendation that was followed?

A That is correct.

Q Now, would the course and efficiency of the local pay system that General Electric has be affected if benefits were not uniform?

A Yes, it would.

Q Could you describe that effect?

A It would have to increase the administrative costs.

Q Do your duties require you to be generally familiar with the term "state mandated benefit laws"?

A Yes.

Q And are you familiar with these laws?

A Yes.

Q What do you understand the term to mean, state mandated benefit laws?

A Well, state mandated benefit laws can take several forms. One would be where, for example, a state law might say if you provide services for a physician [1-134] who renders a particular kind of service, then if it's rendered by a chiropractor, you must provide benefits. Another form of mandated benefit laws would be one that says that you must provide coverage for certain types of individuals in specified dollar amounts or in specified rates.

Q And some deal with specific conditions?

A Yes.

Q And some require certain parity between benefits for one type of care and benefits for another type of care?

A That is correct.

Q And do the coverage of these laws sometime depend upon the residence of the employee?

A Yes.

Q And sometime depend upon where the employee works?

A Yes.

Q And would they sometimes require that the employee both reside and work in a particular state?

A Yes.

Q Now, would mandated health benefit laws have any impact upon the General Electric plan?

A Yes.

Q What would that impact be?

[1-135] A Well, it would completely change the way that we administer our benefits. In other words, let's assume that one of the laws says residence. Then we are now going to have to get information concerning residence status of any claimant, including the dependents. This we don't ned to know at the present time.

Q Well, wouldn't the dependent live with the employee?

A Not necessarily.

Q Could you give some examples?

A Well, you can have divorce situations. You can have children away at college. There are many circumstances where the family is not together necessarily or either temporarily or on a more permanent basis.

Q Would you go ahead and describe other impacts that mandated health benefit laws would have on company plans?

A Well, with our employees all over, where they work and where they reside are not necessarily in the same jurisdiction. So this is bound to cause certain degrees of difficulty, not only administratively, but in the employee relations area. For example, if it says it applies to residents of the state and we have two employees working side by side, one of [1-136] whom is a resident of a state that has a mandated benefit and another one who is not, they have different benefits, and this can certainly create employee relation problems.

Q Does General Electric have facilities close to state borders?

A A significant number of them.

Q Can you give examples?

A Well, let's take New Hampshire. We have a plant in Somersworth, New Hampshire. You can stand in the parking lot and throw a stone into Maine just across a stream. We have a major facility in Cincinnati, Ohio, and I know for a fact a number of employees that work in that facility reside in Kentucky. It's indicated in Exhibit 6, if you look at Louisville, Kentucky, we have almost 20,000 employees in major appliance, and some of them live across the river. So we have—well, even in Massachusetts, I know that some of the employees who work in Pittsfield, in fact, live in New York State because we recently had to offer an HMO to them.

Q Are there any facilities located in New York State near the Massachusetts border?

[1-137] A Yes, there are facilities. We have Selkirk, New York, that's fairly close to Massachusetts. We have Waterford. I wouldn't be surprised at all if some of the employees in Schenectady, do, in fact, live in Massachusetts.

Q With respect to the uniformity of the General Electric plans, would mandated health benefits have any impact on them?

A On uniformity? Oh, yes, it definitely would change.

Q In what way?

A Well, if there are mandated benefits and you have to provide them, then you are going to have a series of different benefit arrangements depending upon the mandated benefits that have been enacted, and this could cause a lot of problems. Assume, for the sake of discussion, that we are talking about a Massachusetts employee with a family, and the social worker, as I understand it, applies to Massachusetts residents. Let's assume for the sake of discussion that marital discord happens;

there is a divorce; the spouse who remains in Massachusetts has the children; our employee is transferred to California. Now, clearly the children still are eligible dependents under the terms of the General Electric [1-138] insurance plan, and probably the divorce decree would require that our employee would provide medical coverage for the dependent, the dependent children. So they are in Massachusetts, presumably subject to the Massachusetts social worker statute, but here our employee is in California. Again, looking at it in terms of our local pay operations, with these possibilities plus transfers plus college and other things, everyone of our 23 local pays would have to adapt to all these mandated benefits.

Q Would the mandated health benefit laws have any impact on the choice of benefits that are made by workers and that are negotiated during the collective bargaining process?

A Yes.

Q Would you give an example?

A Well, social workers were discussed in the last negotiation. They were a specific union demand. The final settlement did not contain that, and this must represent the conclusion of collective bargaining. Now, if there are mandated benefits, it's changing what was negotiated at the table.

Q Where does the cost of that come from?

A Well, it's got to come out of the total somewhere.

[1-139] Q Would the mandated benefit health laws have any impact upon employee morale?

A I think the answer is yes.

Q Could you explain that?

A Well, we can have workers side by side with a different benefit package, or we can have situations where the dependents of one employee get one set of benefits and the dependents of another employee don't have those same benefits because of, perhaps, residence.

Q Now, you testified before about the guidelines and the cookbook. Is there right now one set of guidelines or one cookbook for the entire country?

A Yes.

Q Would the mandated benefit laws have any effect upon that?

A Oh, absolutely.

Q Would you explain that?

A Well, if I could, I would like to explain it in two pieces to try to see what is happening. At the present time we really have four calculation procedures in our system. We have to have a calculation procedure for the A1 that is 100 percent, and this would take care of our $1,000 out-of-pocket [1-140] and our second search. Then we have the A2 calculation field which says, okay, $500 in full and then 85 percent. So that's number two. Number three is the Type B, excluding the outpatient psychiatric, which has the deductibles and 85 percent. Finally, we have a fourth trail, if you want to look at it that way, where we are calculating on the 50 percent basis for outpatient psychiatric. So we have four.

Along comes the state and puts in a mandated benefit of some kind. It means we are going to have another trail. Then another state comes along with another set of requirements, and so far the mandated benefits I've seen are different. So that means another computation trail. So instead of having four, if we go to the extreme of saying that every state is going to have one, we are going to have a separate calculation system to determine benefits properly for each of these states, plus our standard.

So now instead of having four calculation trails, we could have as many as 54 calculation trails.

Now, to continue, if I may. Our carrier is going to have to give us the guidelines or the rules that apply in using these benefits under these state mandated benefits. So they are going to have [1-141] to make a determination of how and to what extent do these apply. Now, I

can see that this could get pretty complicated. For example, one state says it applies to employees and residents, and another state it applies to employees, and another one says residents. So now let's assume that the employee resides in state A that says residents, but he works in state B which says employees, and the benefits are different. Which kind of benefits do we give him? I guess there's an answer, but it complicates the thing.

I can go one step further in that some of our employees have jobs that require them to work in a number of states, for example, sales jobs. Perhaps there could even be someone here in Massachusetts that has as his assignment calling on customers in Massachusetts as well as Vermont, New Hampshire, and Maine. If we have four different benefit laws and they relate to employment, how are you going to determine which apply? Now, I'm not saying that it's insolvable, but it's sure adds to complications and completely destroys our uniform benefit structure.

Q What will you have to do with the cookbook? [1-142] A It would grow substantially to cover all of this. Now, it doesn't stop there because in order to get the information necessary to process claims—assuming this plethora of mandated benefit laws—we are going to have to change the claim form. We are going to have to ask additional questions presumably broad enough so that we can cover all of these different variations. First of all, employees have a little reluctance in supplying information. This concept of privacy seems to be rearing its head more and more when employees don't wait to supply information. Then if you have added ten more questions, presumably in the claim processing cycle, you have got to examine and review ten more questions, which, again, offers the chance for more mistakes, both on the part of the employee and on the part of our claims processor, since there are more. The logic of getting the answers into the system—we are going to have to do this by computer in a larger operations. There is no

way around it—creates the opportunity for more errors in input data.

Q Would you look again at Exhibit 2, which is the General Electric Summary Plan Description?

[1-143] A Yes.

Q I think you testified that ERISA requires you to put out a description in language that the ordinary employee can understand?

A Yes.

Q How would mandated benefit laws affect publications such as Exhibit 2?

A Well, we would have to expand the summary plan description to cover each state mandated benefit. I agree, we printed a lot of these, but the cost of each page of this document is $6,000. So if we had 50 more pages to put in because of mandated benefits—maybe we could do it with less than 50—that's a lot of additional expense. I would add one more thing. It seems that the laws keep changing, and so we would have to be alert to any change in mandated benefits as they occur, and this, in itself, would create problems because an employee can incur an expense before a change in the law and another expense incurred later, one would think he would get the new benefit, where actually the expense was incurred prior to the effective date of the change. So this would mean tracking the actions with respect to mandated benefits in all the jurisdictions and [1-144] making appropriate changes in our computation systems.

If I may carry that just step further, if you were making a change in a computer system then you sort of have to keep the old one in place for some period of time pending receipt of claims that were incurred prior to the effective date of the change. So my 54 systems, if you had 20 of them that changed, you add 20 more trails to be followed in the computer.

Q Now, let me stay with the computers for a minute. Couldn't computers solve some of these problems?

A Let me answer the question this way. The computer can be programmed to do almost anything that a person can do with pen and pencil. It's just a fast, accurate way to do something that otherwise can be done by a manual means. It's the only effective way to handle large volumes of data. I testified earlier that we received 1,294,000 Type A2 and B claims last year. So we would really have to do it by computer. But every time you make a change you have to reprogram. You have to debug that program to make sure it's working right, and the more of these trails or bubbles or whatever term you would [1-145] like to use are added on, it's going to increase the running time and the cost of processing claims.

Q Now, approximately what are your current administrative costs with respect to health plans?

A On a conservative basis I would say $5,000,000.

Q How do you get that figure? Is that just the A2 and B claims?

A Yes.

Q How do you get to that figure?

A Well, I have used a relatively conservative cost of $4 per claim, which multiplied by the almost 1.3 million claims is where I got to $5,000,000.

Q Now, do you have any opinion as to what the cost impact would be on these administrative items if mandated benefit laws expanded and increased?

MR. MONTGOMERY: Objection.

THE COURT: Sustained at this stage unless a better foundation is laid.

Q Is it one of your duties to follow mandated benefit laws?

A Yes, it is.

Q And have you noticed any trend with respect to such laws?

A There are more of them.

[1-146] Q And as part of your duties are you generally familiar with the doctrine specified in Wadsworth against Whalen?

A You mean what the—I'm sorry, I don't quite understand the term "doctrine."

THE COURT: Do you know what the case held?

Q Do you know what the holding was in Wadsworth against Whalen?

A Yes.

Q Now, if Wadsworth and Whalen becomes the rule and if the mandated benefit laws expand as they have been expanding as you testified, do you have any opinion as to how that would affect your administrative costs?

A It would increase it substantially.

Q By what factor?

A Easily five times.

Q What's the basis of that?

A Because of the additional trails that we would have to add to our system, our claim form changes, our processing. That's the basis of my opinion.

Q So you are talking administrative costs of an excess of $25,000,000 for General Electric alone?

A That is correct.

Q What would be the additional premium costs if mandated benefit laws continue to expand and if the [1-147] Wadsworth rule is upheld?

A Well, it would be the sum of the additional benefits themselves on an incurred basis that had been mandated, plus the additional administrative costs charged to us by the carrier, and, I assume, a piece on retention.

Q Could you quantify it with respect to the request for social worker service made by the union in 1979 and rejected at the collective bargaining tables?

A Yes.

Q Would you do so, please?

A As a part of my responsibility in costing alternatives that might be considered for inclusion in the package in negotiations, I did work with Metropolitan in arriving at some estimated costs of including social workers. The amounts that we calculated, depending upon the configuration of the benefit structure, were between

$1,600,000 and $2,700,000. But I would like to add, to make sure this is clear, that this was talking on a uniform basis, in other words, the same social worker benefit all over, not having variations by state jurisdictions.

Q And if there were variations, that would increase the cost?

A It would have to increase the cost.

[1-148] Q By several factors?

A It could be, yes, sir.

Q Now, has General Electric considered alternative means for coping with mandated benefit laws?

A We are.

Q And what are the means that you are considering?

A Non-insurance.

Q What would be your reasons for going non-insurance?

A Well, I understand that if we were not insured, that the mandated benefit laws would not apply, and we could have our uniform system of benefits.

Q Would you have any other reason for going non-insurance?

A No.

* * * *

[2-4]

JOHN D. MORRIS, Resumed

CROSS-EXAMINATION
BY MR. MONTGOMERY:

Q Mr. Morris, you testified yesterday that there were three general classes of employees covered by the G.E. plan?

A I did.

Q Would you please repeat for me, please, those three classifications?

A They are wage or pay classes. There are exempt employees, non-exempt salaried employees, and hourly rated employees.

Q Now, are the benefits which each of those classes of employees receives under the plan all collectively bargained?

A Not all employees of the company are in collective [2-5] bargaining units.

Q Now, what percentage of the company's employees are in collective bargaining?

A About 40 percent.

Q Now, you also testified yesterday that since its inception the G.E. plan has been a uniform plan for all employees covered by the plan.

A I made that statement with respect to medical benefits.

Q Now, in reviewing the document that was submitted as Exhibit 1, you would agree however that the plan does take account of a number of different state laws in its benefit provision?

A The weekly sickness and accident benefits are subject to state disability benefits laws.

Q And those state disability benefit laws vary from state to state, correct?

A There are a limited number of laws; the provisions are not the same.

Q Now, referring specifically to page 23 of the document marked as Exhibit 1, that provides—excuse me, page 21—that's a special page applicable to New Jersey employees; isn't that true?

A That's correct.

[2-6] Q And doesn't that particular page reflect an additional cost per month that's deducted from the pay check of each New Jersey employee?

A That is correct. They contribute $.64 a month.

Q And is it also true that that New Jersey disability law results in the availability of benefits to New Jersey employees that are not otherwise available to G.E. employees?

A There are some minor benefits, yes.

Q Now, referring to page 23, that is a special provision applicable to New York employees, isn't that?

A Yes, it is.

Q And does the New York statute referred to in this page 23 also provide additional benefits not otherwise available to G.E. employees?

A There is an additional benefit which is that in the event of termination of employment, as stated on the page, coverage is continued for twenty-eight days unless the individual gains employment with another employer covered by the New York disability benefits law.

Q That's in effect a conversion provision?

A No, it's a continuation provision.

[2-7] Q A continuation provision?

A Yes.

Q Now, page 24, there's a special provision relative to Rhode Island employees?

A Yes, there is. Rhode Island has a monopolistic fund, so they pay the benefits and we, in effect, top the benefits off because our plan benefits are richer.

Q So, would it be fair to say that while the plan may be uniform, the benefits that are available to G.E. employees may vary to some extent, depending on the state—

MR. GREENFIELD: You're talking about disability benefits.

MR. MONTGOMERY: With respect to those three pages, I'm talking about.

THE COURT: Well, when you object, object.

MR. GREENFIELD: Object.

THE COURT: And don't object in the middle of the question, please.

MR. GREENFIELD: I object.

THE COURT: I don't think he's finished his question, are you, sir?

[2-8] MR. MONTGOMERY: No, your Honor.

THE COURT: That's what I figured. Why don't you ask your question, and then we'll allow time for an objection.

MR. MONTGOMERY: Thank you.

Q Would it be fair to say, Mr. Morris that while the G.E. plan may be uniform, the benefits which are available to G.E. employees in certain respects exhibited by example on pages 21 through 24 of Exhibit 1 may vary from state to state?

THE COURT: Now, is there an objection?

MR. GREENFIELD: Yes, your Honor, he's not specifying what type of benefit he's talking about.

THE COURT: Your objection's overruled; your rights are saved. You may answer, sir, if you understand the question.

A The plan document, which we are both looking at or have looked at, states that with respect to disability benefits, which is weekly sickness and accident, in other words, pay for an individual who is absent from work because of disability, do vary in very minor ways in four jurisdictions.

Q Now, do you consider these disability statutes in [2-9] these four states to be mandated benefit statutes, which is a term I think that you used in your direct examination yesterday?

MR. GREENFIELD: Your Honor, I would like to object on another ground. It's my understanding and I think I'm right, that disability statutes are not covered by ERISA at all.

THE COURT: That may be true, but the question, I believe, is proper. You can clear that up.

A Yes, I guess I would say the state has mandated that if you're going to do business in the state, you must have these particular benefits.

Q Now, do these various disability statutes, do they result in an additional administrative burden, cost burden, on your employee plans?

A As a practical matter, no.

Q If, hypothetically, all fifty states had different disability laws, would that add an administrative burden, as a practical matter, for your plan?

A I really can't answer that question because I don't know what the other statutes would say.

Q Now, you also testified yesterday, with respect to another document, Exhibit 3, which I believe is [2-10] a list of union demands in the most recent contract negotiations between the union and General Electric.

A That is correct.

Q And I believe you testified that in the course of negotiations with which you were personally familiar there was some give and take between the parties with respect to these various demands. Is that a fair summary of what your testimony was yesterday?

A Yes.

Q Now, would you also agree, however, that the participants in that collective bargaining process also recognized an obligation to comply with various differing state laws?

A I don't quite understand what—

Q Well, let me try to rephrase it. Did the parties to that negotiation understand that they had an obligation —strike that. Did the parties in that negotiation understand there were different state laws which were applicable to various portions of the benefit package?

MR. GREENFIELD: Objection. He cannot know what the parties understood, only what they [2-11] said.

THE COURT: Well, you asked the same question yourself.

MR. GREENFIELD: I do not think I asked him what other people, the operation of another person's mind.

THE COURT: You did.

MR. GREENFIELD: I shouldn't have.

THE COURT: I make mistakes every day. You can answer.

A The parties certainly were aware of the existence of the New York, California, Rhode Island and New Jersey disability benefits laws. They'd been in place, I think in California in the '40's.

Q Didn't the parties include expressly in the collective bargaining agreement a provision which preserved the right to vary the plan in accordance with any applicable state or federal law which may vary or require variance of the terms of the plan?

A That is correct.

Q Okay. And isn't that a traditional provision in collective bargaining agreements, that a savings provision for alterations in state or federal law?

A I can't answer that. I only know what—

[2-12] Q You've never seen such a provision in any other collective bargaining agreement in your experience with G.E.?

A Only in our agreements.

Q Okay. But that has been a provision that's been in your agreements down through the years?

A Yes, to the best of my knowledge.

* * * *

[2-16] Q Now, if you could, Mr. Morris, I'd like you to just briefly explain what the G.E. plan benefits are for treatment of mental or nervous conditions?

A I would put them in two categories. The first would be those benefits associated with confinements, hospital confinements. In that case, the hospital charges are paid in full and this, of course, all of this is subject to the lifetime maximum of $350,000. With respect to the services, of a psychiatrist or a psychologist, as defined in the plan, for a person who is confined in a hospital it would be a Type B expense reimbursable at the rate of 85 percent after the deductible. If the person has outpatient psychiatric care for an illness or condition, then the benefit rate is [2-17] 50 percent after the deductible.

Q Okay. Now, does the plan distinguish between, in its reimbursement, between general hospitals, accredited general hospitals, and mental hospitals, licensed by the state?

A As long as it meets the definition of hospital.

Q Well, would a mental hospital licensed by the Department of Public Health in Massachusetts meet the definition of hospital under your plan?

A I don't know, but I suspect it would.

Q And how about a private as opposed to a public mental hospital licensed by the Department of Public Health; do you think that would comply with the definition of hospital under your plan?

A I would expect so.

Q Now, are psychiatrists and psychologists reimbursed on an equal basis under the plan?

A Yes.

Q So there is no requirement that a psychologist may not be reimbursed except in the event of a referral by the physician or supervision by a physician?

A We have defined psychologist in the plan. And if the psychologist meets the definition of the [2-18] plan, he would be treated the same, assuming, of course, that the person is in fact treating an illness or injury condition.

Q Now, so far as I can tell, at least with respect to everything you've mentioned so far, the G.E. plan is in compliance with the minimum standards of the Massachusetts statute. What I'm trying to do is discover in what respect it does not comply since, unlike many of the plans that are issued here, it seems to comply. You mentioned yesterday social workers, and there was some testimony on direct that social workers are not covered by the G.E. plan.

A For mental health, they are not covered.

Q Now, is it your understanding that the Massachusetts statute requires a reimbursement for treatment by social workers?

A Yes.

Q Are you familiar with the Massachusetts statute?

A I have read it.

Q You've read it. It does not specifically mention social workers, does it?

A My recollection is that it does, but I have not read it for a while.

[2-19] Q Do you recall any mention in the Massachusetts statute of community mental health centers?

A My recollection is that it did mention health centers, mental health centers.

Q And those are community mental health centers licensed by the Commonwealth of Massachusetts?

A I would assume so.

Q Now, is treatment provided in the mental health center licensed by the state covered under the G.E. plan?

A Those services that are covered by the plan would be reimbursed.

Q No. Would services provided in such a setting be covered by the plan?

A If they meet—in other words, if a social worker charge came in, it would not be covered. If a psychologist's charge came in or a psychiatrist as defined in the plan, the benefits would be provided.

* * * *

[2-26] Q Do you know what portion of your current $5 million dollar administrative burden is attributable to the payment of claims for mental or nervous condition?

A No.

MR. MONTGOMERY: No more questions.

[2-27]

REDIRECT EXAMINATION
BY MR. GREENFIELD:

Q Mr. Morris, do your collectively bargained employees receive different benefits than other employees?

A Not health benefits; they're the same.

Q Now, with respect to the health benefits, do you first negotiate with the union?

A Yes.

Q And then you reach a benefit level that's collectively bargained?

A Yes.

Q And then those benefits are then made available for all employees?

A That's correct.

Q Whether they're unionized or not unionized?

A That's correct.

Q And whether it's the president or the super?

A That's correct.

Q I'd like to focus on the New Hampshire statute that you were asked about on cross-examination. That requires that the employee both, as you understand it, both reside and be employed in New Hampshire?

A Yes.

[2-28] Q So if an employee resided in New Hampshire but was temporarily employed in Vermont, as you understand that statute, it wouldn't be covered?

A That's correct.

Q So you would have to keep track of that employee's place of employment at any given time?

A As well as residence.

Q As well as residence. And the problem would become complicated if the employee were an itinerant worker who sometimes worked in one state and sometimes worked in another?

A Yes, it would.

Q Now, you were asked about pages 21 through 24 of Exhibit 1.

A Yes.

Q Do those pages relate to disability benefits?

A They do.

Q And to disability benefits only, am I correct?

A That's correct.

Q Now, how many states have enacted disability benefit laws?

A Five.

Q And for how long have these laws been around?

A With the exception of Hawaii, which is three or four [2-29] years, maybe five years ago, most of them,

the rest of them were enacted either in the late '40's or early '50's.

Q Now, could you describe disability insurance?

A Yes. The disability benefits which in the plan we call weekly sickness and accident benefits provide that if an employee is disabled because of a non-occupational illness or injury, benefits are payable during the duration of the disability; specifically, the benefit rate is 60 percent of the employee's, what we call, a normal straight time annual earnings—it's straight time pay on a regular basis, with a maximum currently of $200 a week. Benefits begin on the eighth day of disability, unless the individual is hospitalized earlier, for which case they start the first day of hospitalization, and they extend for a maximum of twenty-six weeks.

Q Now, the disability level, you just said 60 percent?

A Yes.

Q Is that higher than the disability levels provided for in the statutes in the five or six states that have the statutes?

A With the exception of New Jersey, which has a [2-30] two-thirds formula, it is higher. However, New Jersey, as I recall—I can look and see—currently has a maximum of $117 as compared to our $200, and as a practical matter I can't think of any cases I've heard about in recent years where our 60 percent of pay with the $200 max was not higher than the New Jersey benefit.

Q So, as a practical matter, what you are giving in that regard is more than the state statutes require?

A That is correct.

Q Now, do these disability statutes have any significant cost impliactions to General Electric?

A No.

Q Can you explain why not?

A Well, what the additions that were mandated through these disability benefit laws are really rare cases where anything is payable above the benefit level of our

plan or in addition to the benefit level. California, for example, now has benefits for thirty-nine weeks, but there are relatively few cases where we ever go twenty-six weeks of the total. Similarly, I mentioned earlier, New York requires continuation of coverage for twenty-eight [2-31] days. But, again, while we do have employees in New York who do terminate, they have to become disabled within that twenty-eight day period and before going to work for another employer to receive this benefit. So the frequency of these items is low.

Q Who bears the additional cost?

A The employees.

Q And you simply take something out of their payroll checks—

A That's correct.

Q In California and New York?

A In California, New York and New Jersey.

Q Now, do you have any data comparing the amount of claims under disability as compared to claims for A-2 and B benefits?

A Yes.

Q And what does that data show?

A We have about 50,000 weekly sickness and accident claims a year, and that compares with, as I recall, I testified 1,294,000 type A-2 and B claims a year.

Q So it's significantly less than 5 percent?

A Yes.

[2-32] MR. GREENFIELD: No other questions.

RECROSS-EXAMINATION
BY MR. MONTGOMERY:

Q Mr. Morris, do you consider state laws which existed previous to the amendments to Title 7 concerning pregnancy-related disability to be disability laws?

A I—

Q Maybe I'm confusing you. Are you aware that various states have had laws requiring the payment by employers of pregnancy-related disability?

A Yes.

Q Do you consider those disability laws?

A If they require the payment of disability benefits, yes.

Q Now, are you familiar with a Massachusetts regulation promulgated by the Massachusetts Commission on Discrimination which required such payment by all employers in the Commonwealth?

A Yes.

Q You're familiar with that?

A I'm aware that such a thing exists.

Q Do you know when that particular law went into effect?

A I do not.

[2-33] Q Now, does the G.E. plan, did the G.E. plan prior to last year provide for such disability payment?

A The plan provided for payments beginning January 1, 1979.

Q So that the plan did not comply with the Massachusetts statute?

MR. GREENFIELD: Objection. That's a question of law.

THE COURT: Well, it could be a question of fact. It's a question of mixed fact and law, I guess. I'm going to go on the fact side and have the question answered. You can answer, sir, if you can, if you know.

A Well, would you state the question again? I'm sorry.

Q Prior to January 1 of 1979 did the General Electric employee benefit plan provide benefits for pregnancy-related disability?

A Yes and no. No, in the sense of weekly benefits. Yes, in that as far as medical expense coverage is concerned, the benefits for maternity-related expenses are identical to those for any other illness.

Q Did it provide any wage continuation?

[2-34] A I stated already, no, it did not.

Q Now, did the G.E. plan provide any wage continuation for other disabilities covered under the law?

A Yes.

MR. MONTGOMERY: Your Honor, may I have just a moment.

Q With respect to benefits for pregnancy-related disabilities prior to January 1, 1979, were the benefits for the plan standard across the country?

A Except as mandated by the five states.

Q Which five states?

A The California, New York, New Jersey, Rhode Island.

Q But not include Massachusetts?

A That's correct.

Q Are you aware of any other states besides the ones you just mentioned plus Massachusetts that had such statutes requiring payment for pregnancy-related disabilities on the same basis as for any other disabilities covered under a plan?

A I think there were other statutes.

* * * *

[2-35]

[TESTIMONY OF MARTIN J. FRANK]

DIRECT EXAMINATION
BY MR. DOPPELT:

Q Mr. Frank, please state your name, home and office address.

A My name is Martin J. Frank. I live at 106 Haverford Road, Pittsburgh, Pennsylvania. My office is at 600 Grant Street, Suite 4675, Pittsburgh, Pennsylvania.

Q Please trace your background briefly, starting with college.

A I graduated from the University of Michigan in 1958 with a mathematics degree. I then went to Mutual Life Insurance Company of New York as an actuarial trainee. I spent six and a half years at Mutual of New

York where my last few years I was in their group insurance department doing group insurance actuarial work as well as supervising the group underwriting portion of the group department. In 1964, I moved to Detroit, Michigan and became the actuarial consultant to the United Automobile Workers. I was in Detroit from 1964 to 1969, and in 1969 I went to Towers, Perrin, Forster & Crosby, where I am today. I've been there for eleven years and [2-36] have been in T.P.F. & C.'s Philadelphia office and now in their Pittsburgh consulting office.

Q What degrees do you hold?

A I have a Bachelor Degree in Mathematics from the University of Michigan, and I am a member of the Society of Actuaries, the Academy of Actuaries and the Conference of Actuaries in Public Practice.

Q Could you briefly explain what your responsibilities were at the United Auto Workers?

A I was the, as I said, my title was Actuarial Consultant. I reported to Mr. Walter Ruether, responsible for assisting the United Automobile Workers in their strategic plans for collective bargaining on employee benefit matters. In addition to working in that area, I also helped the UAW formulate its social policies with respect to pensions and supplemental unemployment benefits and health care. And in 1966, I helped the UAW work on Medicare legislation.

Q While at the UAW, were you involved in any specific collective bargaining negotiations?

A Yes.

Q Could you give us an example of one such negotiation?

[2-37] A Well, between 1964 and 1969, I was involved in what I like to call pattern-setting negotiations. Those were the negotiations in the big three automobile companies: Ford, GM and Chrysler. And I was also involved in a number of other parts supplier corporations like Dana Corporation, Champion Sparkplugs, and I was also involved in aerospace negotiations and in a number

of agricultural implement negotiations, like International Harvester, Caterpillar, John Deere Company.

Q You mentioned the phrase pattern-setting negotiations; could you briefly explain what you mean by that?

A Well, the UAW has a tradition of picking one of the major automobile companies and trying to hammer out an agreement with the major company. After that agreement is negotiated, then the UAW turns to the other big automobile manufacturers and tries to negotiate the same contract. The UAW represents about a million and a half workers, at least it did when I was employed at the UAW, and it then takes that contract from GM, Ford and Chrysler and moves on to the automobile implement [2-38] companies and other companies as well, who the UAW represents who are not even in the automobile industry.

Q What are your responsibilities now at Towers, Perrin, Forster & Crosby?

A Well, I'm the manager of TPF & C's Pittsburgh consulting office. I'm an actuarial employee benefits consultant for a number of major clients, and I am practice leader for TPF & C's labor relations consulting service on a worldwide basis.

Q Are you an officer or partner of TPF & C?

A Yes, I'm Vice-President of the firm, and I'm a principal in the firm; we're a corporation, not a partnership.

Q Can you briefly explain what TPF & C does?

A We're a management-consulting firm, and we work with a number of clients. We represent approximately 3,000 clients on a worldwide basis. To give you an idea of the clients we work for, we represent sixty of the Fortune 100 companies and approximately two hundred and sixty of the Fortune 500 companies. And we work in areas like employee benefit consulting, actuarial services, salary administration, executive compensation, and then we're into human resource [2-39] management services, such as labor relations, management succession, career development and into general management services,

such as organization development, strategic planning and a number of other service areas.

Q Do you provide services to a number of large companies?

A Yes, we do.

Q A number of Fortune 500 companies?

A Yes. I mentioned two hundred and sixty of the Fortune 500.

Q Could you explain what practice leader for labor relations means?

A Well, I'm responsible for the quality control of all of our services for all of those clients who we work with labor relations. We have approximately six practice leaders in the company, and we have 1,500 employees.

Q And so you are the top man at your company with respect to labor relations?

A Yes, sir.

Q What are your responsibilities, with respect to advising clients concerning collective bargaining matters? [2-40] A I work with clients not only in the Pittsburgh office but as I mentioned with clients all over the United States, and I help them in formulating their collective bargaining strategy in collective bargaining matters on employee benefits.

Q Do you actually participate in the collective bargaining process?

A Yes, I do. For most clients I'm involved in the process, but for some clients I'm just as an advisor, and I'm either contacted by telephone or I'll be on-site, but I won't be in the actual collective bargaining.

Q And, do you advise clients with respect to matters concerning health benefits for employees?

A Yes, I do.

Q Can you explain what is meant by the term health benefit?

A Well, I would define health benefits under a collective bargaining agreement as those benefits covering hospital reimbursement, surgical reimbursement, medical

reimbursement—that is, doctor bills, either inside or outside the hospital, or in an office or at home—I would [2-41] also include dental benefits. I would include eye care, vision care, those kinds of benefits I would deem health benefits.

Q At one time or another then, you have engaged in collective bargaining negotiations for both union and management?

A Yes, I have. Five years with the union movement and now eleven years on the other side of the bargaining table.

* * * *

[2-44] Q Could you describe the role of health benefits in the collective bargaining process?

A Well, I would consider, in my opinion, I would consider that health benefits are really a very central part of the collective bargaining agreement, and I guess I form that opinion on the basis of my experience in collective bargaining. The parties spend a lot of time discussing the health benefits portion of a collective bargaining [2-45] agreement.

Q Will the union ever consider what the significance of the health benefit package is with respect to the ratification of it?

A Yes.

THE COURT: I'm very sorry, I didn't hear the last—

Q With respect to the ratification vote on the collective bargaining agreement?

A Oh, yes, definitely. When the union is negotiating a contract it's very, very important that the contract that they end up be in the minds and the perceptions of the people who they represent, be what they wanted. And before a union can get a final agreement it must get a ratification vote from the members. And so it's terribly important that when the union puts its package together that that package cover a number of areas which have a very high visibility to the members they represent.

Q And health benefits is such an area?

A Oh, yes, sir.

Q Based on your experience, could you estimate the cost of employee fringe benefits in terms of [2-46] payroll?

A I think I would estimate that the cost of employee benefits in the United States is probably between 30 and 40 percent of payroll on an all-company basis.

Q Based on your experience could you estimate the percentage of health benefits as a percentage of employer payroll nationwide?

A I would say it would be between 5 and 10 percent of payroll.

Q Now, Mr. Frank, with respect to the companies that you advise would you describe the actual manner in which health benefits are negotiated in the collective bargaining process?

A Just like wages or just like pensions the union will make proposals for amendments to the collective bargaining agreement as it relates to health benefits. There will be proposals with respect to hospital reimbursements, deductibles, co-insurances, dental benefits, vision care benefits. Each particular item of health care is discussed in collective bargaining.

Q Will the union and employer generally discuss the need for or desirability of a given benefit on the [2-47] table?

A Yes. It's very common for the parties to discuss philosophically, does this benefit make sense for the union's members and for the employees of the corporation. Is it too costly? What will the utilization be? How much will the administrative expense be? Will people understand the benefit? Are other benefits more important to the members? So, yes, it's discussed in great detail.

Q And on a practical level, will the employer and union generally discuss the detail aspects of the coverage such as co-insurance?

A Yes, limits, co-insurances, deductibles, first-day coverage, eighth-day coverage. It's discussed in great detail.

Q Now, how common is this type of bargaining over mental and nervous-type benefits?

A Very common.

Q Have you been involved in any recent collective bargaining negotiations in which mental and nervous benefits have been discussed?

A Yes, I have.

Q Could you give us an example of one such—

A I was involved in the B.F. Goodrich negotiations [2-48] with United Rubber Workers in Columbus, Ohio when the B.F. Goodrich Company made their pattern settlement. I use the term pattern just like I've used it in the automobile because that pattern settlement then evolved with the coverage for the rest of the rubber industry.

MR. DOPPELT: I'd like to ask the reporter to mark as Exhibit 9 for Identification, the document headed, Agreement on Employee Benefit Programs, dated September 6, 1976 between the B.F. Goodrich Company and International Union of United Rubber, Cork, Linoleum and Plastic Workers of America and local unions.

THE COURT: Show it first—

MR. DOPPELT: Opposing counsel has seen it.

MR. MONTGOMERY: And we don't object to its admission.

(Agreement, above-referred to, marked Exhibit No. 9)

MR. DOPPELT: May I approach the witness, your Honor?

THE COURT: Let me read this over, please.

[2-49] Q Mr. Frank, I hand you Exhibit 9 and ask you if you can explain what that document represents.

A Well, this is page 49 of the agreement on employee benefits and it highlights Section D which is the mental,

psychoneurotic or personality disorder conditions benefit that was negotiated in the 1976 agreement.

Q And what did that benefit provide with respect to the amount of coverage for the mental benefits?

A Well, subject to various deductibles it provides a $30 per professional services visit at the rate of 50 percent co-insurance, and there's a maximum of $750 per calendar year.

Q Did the union develop a proposal with respect to this benefit for the 1979 negotiations?

A Yes, they did.

MR. DOPPELT: I'd like the reporter now to mark as Exhibit 10 for admission into evidence, a document headed Columbus Ohio 2/26/79, Union Proposal.

THE COURT: On behalf of the Commonwealth?

MS. KELLY: No objection, your Honor.

THE COURT: It may be marked Exhibit 10.

(Proposal, above-referred to, marked Exhibit No. 10)

[2-50] Q Mr. Frank, is Exhibit 10 a copy of the union proposal with respect to the mental and nervous benefits?

A Yes, it is.

Q And could you tell us what the union proposal states with respect to the amount of coverage per visit and maximum per year?

A Well, the union was demanding that the $30 benefit be increased to $50 and that the maximum benefit be increased from $750 to $1,000.

Q Would this document have been provided to management with respect to 1979 collective bargaining negotiations?

A Yes, this was passed across the bargaining table.

Q And was this proposal discussed in the 1979 negotiations?

A I'm sure it was.

Q And was an agreement reached with respect to this provision?

A Yes, there was.

MR. DOPPELT: I'd like to ask the reporter to mark as Exhibit 11, with the Commonwealth's permission for admission, a document headed 12.3(a)(b).

[2-51] MS. KELLY: The Commonwealth has no objection, your Honor.

THE COURT: Okay, it may be marked.

(Document, above-referred to, marked Exhibit No. 11)

THE COURT: This apparently is some sort of—apparently some sort of amended—amended to be attached to the contract, or something like that?

MR. DOPPELT: I will ask the witness to explain.

THE COURT: I want to write it in my book first, so I can understand it.

MR. DOPPELT: As I understand it, it is a page from the 1979 agreement, which refers to the 1976 agreement.

THE COURT: Okay. So this is like one that is to be amended to the contract?

MR. DOPPELT: Right.

Q Mr. Frank, could you explain what Exhibit 11 is, please?

A This is a page from the memorandum of agreement where the parties reached agreement and summarized the changes that would be effectuated in the 1979 agreement. And specifically here, it shows that [2-52] the daily rate, or the per visit rate, excuse me, which was $30 would now go to $45 and that the $750 maximum would go to $1125.

THE COURT: We're going to take a short recess. Is that okay? We won't make this the usual long morning recess, just about five minutes.

(Recess.)

Q Mr. Frank, just so that the record is clear, would you please explain what precisely Exhibit 11 is once more?

A This is a page from what I like to refer to as the memorandum of understanding between the union and management just after collective bargaining agreement has been signed. And this is not the legal language that goes into the agreement; this is just a memorandum of understanding, and then it's written up after the ratification vote.

Q And this is the memorandum for the 1979 negotiations?

A Yes, it is.

Q And the provision that you were reading from with respect to the $45 and $1,125 increases is 12.7(d)?

A Yes.

Q And that provision refers back to the '76 agreement?

[2-53] A Yes.

Q What are some of the factors involved in the union and the employer reaching an agreement on the final package?

A Well, some of the factors involved are the cost, the total cost of the program, whether or not the union needs either more in wages or more in health insurance or more in pension. It's a collective bargaining process, and it's the whole package that comes into being not just parts of the package.

Q Will the parties reach final agreement on each aspect of the packages as they move through negotiations, or will agreement await the end of negotiations?

A It's most common for the total agreement to come into being in the last hours of negotiations.

Q And will the union and the employer have any sort of cost estimates in mind for the total package that they're willing to accept?

A It's common for them to discuss costs. There are a number of negotiations that I've been in where costs

were never discussed at the bargaining table, but rather philosophical arguments about whether or not a benefit should be in the program.

[2-54] Q Before the negotiations begin will the employer or the union formulate some general notion as to what type of overall package they are willing to accept?

A Yes. It's common for the chief negotiator for the company to have a maximum economic point at which he can no longer go over. He has direction from top management for the total cost of the package. On the other side of the table, the union leaders have a feeling as to the minimum amount that they can settle on either from a cost standpoint or from a benefit standpoint. This again, as I mentioned a few moments ago, you have to go back with that agreement and get a ratification vote, so it's terribly important to deliver an agreement to the company.

Q What, if any, is the relationship between the resolution of disputes or issues in the health benefit area and the resolution of issues in other areas such as wages or pensions?

A They're very similar. I've been in negotiations where health benefits were traded for wage increases or where wage increases or money that was set aside for wage increases earlier on in negotiations were [2-55] set aside for pension increases as the whole package comes into being for final agreement.

Q Will certain employers purchase group health insurance policies to implement the promises contained in the collective bargaining agreement with respect to health benefits?

A Yes.

Q And what will the relationship be between the benefits as set forth in the collective bargaining and the benefits to be provided through the insurance policy?

A Identical.

Q Are you aware that there are a number of state laws which require group insurance policies to provide

certain specified health benefits regardless of the actual terms of the collective bargaining agreement?

A It's my understanding that there are state laws like that, yes.

Q Are you aware that the Commonwealth of Massachusetts has enacted such a law?

A Yes, I am.

Q Have you read the Massachusetts statute?

A Yes, I have.

[2-56] Q Do you know whether other states have similar type laws?

A It's my understanding that there are similar type laws in other states.

Q Based on your experience, do you have an opinion as to what the effect of these laws will be on the collective bargaining process and the agreements reached in that process?

A Well, it's my opinion that state laws like this requiring parties to agree beforehand can be very disruptive to the collective bargaining process and could possibly cause problems for the whole process of collective bargaining. It seems to me that if parties are going to negotiate over employee benefit matters, then they should have freedom as to bargain over those benefit matters and for them to come to the bargaining table and for part of the contract to be already agreed to will make it difficult for the free collective bargaining process to continue. Also, it's terribly important in collective bargaining, in my opinion, for the parties to have maximum flexibility. And to the extent that there are coverages which are required, there is less [2-57] flexibility, and there's obviously less trading that can be done in collective bargaining because there's only so much money the parties can spend. And if part of the agreement is stipulated, there's less money available for other things that the union might want or that management might want in the collective bargaining process.

MR. DOPPELT: No further questions

CROSS-EXAMINATION
BY MR. MONTGOMERY:

Q Mr. Frank, do you know whether with respect to the B.F. Goodrich agreement that all of the persons who are entitled to benefits under the plan are also subject to the collective bargaining agreement?

A The agreement that you have?

Q Yes.

A It's only for employers who are covered by the United Rubber Workers settlement at various locations around the United States. You're asking are there other employees who are not covered by this collective bargaining agreement who are covered by the same plan?

Q That's right.

A I'm not sure.

Q Are you familiar with the nature of the benefits [2-58] provided to non-union employees of B.F. Goodrich?

A No, I'm sorry, sir, I'm not. My only involvement was assisting B.F. Goodrich in bargaining with this particular union.

Q Well, you do know that this plan does not apply to any other employees?

A No, I don't.

Q So it may—

A Yes, it may.

Q There're benefits included in that plan which may very well apply to non-union employees?

A Yes, it might.

Q Would it be uncommon in your experience for such a plan which has been collectively bargained to apply to non-union employees also?

A I can't say whether it's common or not. It depends on the industry. It depends on the power of the particular union. It depends on whether the company is multi-divisional or multi-product. It's very difficult for me to answer whether it's common or not.

Q Okay. Now, you testified that in your experience, to some extent that benefits, that health insurance benefits are specifically discussed in [2-59] detail in the collective bargaining process. Do you have any experience with collective bargaining negotiations in which the discussion really centers on the level of contribution by the employer to an employee plan as opposed to specific benefits?

A I'm knowledgeable that that occurs, but I do very, very little work in that area.

Q But that does occur?

A It does occur.

Q Now, the collective bargaining agreements that you have experience with, does the negotiation process take account of the variability in state laws across the country to which a plan might be applicable?

A You're referring to a particular kind of a plan now or any kind of plan?

Q I'm asking you a general question. You testified generally with respect to the bargaining process, and I want to know whether the bargaining process takes account of and how it takes account of the various state laws that might apply to the types of benefits which are being provided?

A It might well do that, yes.

[2-60] Q Might there be specific discussion in the course of the bargaining process of the various state laws which might apply to a particular benefit?

A Yes.

Q And is it common in your experience for the plan which results from the negotiations to vary to meet the terms of various state statutes or regulations?

A With respect to the clients who I represent, that would be very unusual because of the level of benefits that are provided for employees on a company-wide basis.

Q So, in general, your benefits exceed the minimum state requirements and, therefore, there would not be an issue with respect to the applicability of those state laws?

A In most cases I would say yes.

Q Now, I'm referring to a document which I don't believe is going to be marked, but it is the B. F. Goodrich agreement, and it mentions on page 1 the term supplemental, local supplemental agreements. Are you familiar with that term?

A Yes, I am.

Q And is it true that the B. F. Goodrich agreement is [2-61] subject to and does not override local supplemental agreements?

A Yes, but the term as used in the B. F. Goodrich agreement refers to local general collective bargaining agreements. That is to say, with respect to working conditions and seniority clauses and union security clauses not with respect to employee benefits. That agreement that you have in your hand is the agreement for all United Rubber Worker employees who work for B. F. Goodrich no matter where the work or what division they're in.

Q What are the types of subjects which are considered in local supplemental agreements?

A It's very difficult for me to answer that question without having those supplemental agreements in front of me, but typically, they're working conditions, subcontracting, time off for lunch, the rate at which the assembly line moves. It's what I refer to as general collective bargaining issues and not economic matters, not like wages and supplemental unemployment benefits or pensions.

Q Well, you just mentioned time off for meals and things like that. Are you aware that various states have different requirements applicable to provisions [2-62] by employers for mealtime?

A No, I wasn't.

Q Mr. Frank, are you familiar with the provision in this agreement which provides that the company may provide benefits through a health maintenance organization subject to applicable state or federal law?

A I wasn't familiar with it, but that doesn't surprise me that a provision like that would be in there.

Q Is that a common provision?

A Yes.

Q Now, you testified that you're familar with various state statutes which mandate certain level of benefits for the treatment of mental and nervous conditions. Are you aware of—

A I said I know of them; I'm not necessarily familiar with them.

Q Do you know of other examples of statutes or regulations which regulate other aspects of the employee-employer relationship which differ from state to state?

A Yes, the disability provision that was mentioned earlier this morning.

Q Have you participated in any collective bargaining [2-63] negotiations which have considered, for instance, the subject of pregnancy-related disabilities that were discussed this morning?

A Yes, I have been in negotiations.

Q Could you describe the nature of those discussions?

A The nature of the discussions would be whether or not a pregnancy-related disability would be treated as if it was any other disability. In other words, whether the benefits would be paid on the same basis as if it were any other kind of non-occupational or occupational disability.

Q In your experience, was any consideration given in any of those discussions to the existence of laws in any of the states which mandated such benefits by employers?

A Yes, I can think of one negotiation I was in where it was discussed.

Q And what was the result of that discussion of that state law?

A That particular discussion was a company in Toledo, Ohio, and they had employees in the State of Michigan, and there was a question whether or not the employees had to be covered, those disabilities that were pregnancy-related. And, as a matter of [2-64] fact, the parties could not reach agreement on that subject because

of the vagueness of whether or not those parties would be covered the same as any other illness. It actually was very disruptive to collective bargaining.

Q Have there been any other occasions that you can recall on which that subject has been discussed?

A Not offhand, sir.

Q But you do believe it was disruptive?

A In this particular case that I was involved in, yes, it was.

Q Now, are you aware of the fact that the various states have different laws mandating different holidays that have to be provided by employers to employees, state holidays?

A Yes, I am aware of that, yes. We have an office here in Boston.

Q And have you participated in any collective bargaining negotiations at which the subject of the differences among the holiday entitlement among the various states has been discussed?

A No, sir, I'm only involved in employee benefits, and the subject of holidays would not be discussed as an employee benefit in a collective bargaining [2-65] agreement, at least the particular—

Q So that is not a fringe benefit?

A No, at least that particular area which I am involved in.

Q Now, are you aware that to some degree the minimum wage may vary from state to state?

A Yes.

Q Have you ever participated in a collective bargaining negotiation at which the difference in the minimum wage from one state to another has been discussed?

A Never discussed in any negotiations that I've been in because of the level of the wages.

Q Are you aware that various states have various laws which address the subject of age discrimination?

A Yes, I am aware of that.

Q Have you participated in any collective bargaining negotiations in which they discussed the differences in those state provisions?

A Yes, I have.

Q And what have been the nature of those discussions?

A In one negotiation in California, which has a provision which is more liberal than the recent age discrimination employment act of 1978 amendment, [2-66] and, of course, the pension plan had to take that into account.

Q So, in fact, it did take it into account. Was that disruptive to the collective bargaining process?

A It certainly was because the bargaining unit was not just California employees but employees on a company-wide basis, and so the pension plan when it was negotiated with the bargaining committee that represented employees from the entire company from plants all over the country, we had to discuss how employees would be allowed to stay on after age 65 in some states versus other states, and we had to arrive at an agreement that made sense to the whole company, and there were obviously employees who were not Californians who had very little interest in discussing that subject.

Q And, as a result of that bargaining agreement were the benefits, the rights of California employees under that agreement different than with respect to age and retirement than employees in the rest of the country?

A In this particular agreement it ended up that the benefits for employees outside of California were [2-67] the same as California employees, and that is why it was disruptive. Because as part of the whole collective bargaining process, money had to be diverted from other portions of the agreement to pick up the additional cost of providing non-California employees the same benefits as California employees.

Q Well, would you then conclude, in general, that any state statute or regulation which has the practical effect of requiring an additional benefit for employees in

one state may be disruptive to the collective bargaining process?

A Would you repeat the very first part of the question?

Q Maybe that wasn't clear. Would you conclude that any state statute which requires a benefit to be provided to employees in that state which is different than what the parties contemplate for the rest of the country may be disruptive to the collective bargaining process?

A It may be disruptive, yes.

* * * *

[2-68]

[TESTIMONY OF WILLIAM L. HYLAND]

DIRECT EXAMINATION
BY MR. McGOVERN:

Q Please state your name and address, sir.

A My name is William L. Hyland. I live at 186 Bueno Vista Drive, Ringwood, New Jersey.

Q And by whom are you employed?

A GTE Service Corporation.

Q What is your business address, Mr. Hyland?

A 1 Stamford Forum, Stamford, Connecticut.

Q What relationship does GTE Service Corporation bear to GTE Corporation itself?

A GTE Service Corporation is a wholly owned subsidiary of General Telephone and Electronics Corporation, General Telephone and Electronics Corporation being [2-69] a holding company and having no employees. GTE Service Corporation has employees that render services to the parent and its subsidiaries on a common basis.

Q The official name of the parent then is—

A General Telephone and Electronics Corporation.

Q And the official name of the service company is—

A GTE Service Corporation.

Q What businesses are General Telephone and Electronics and its various subsidiaries engaged in?

A We're in the telecommunications business. We operate telephone operating companies in thirty states in the United States and three or four foreign jurisdictions and we manufacture telecommunications equipment and electronic products including consumer electronics and related products, allied products.

Q Consumer electronics get you into TVs, radios?

A Televisions, radios, stereo.

Q That is your Sylvania line?

A Yes, those products are branded Sylvania.

Q What is your position, Mr. Hyland, with GTE Service Corporation?

A I'm Vice President, Insurance.

[2-70] Q And can you give the Court, if you will, a brief description of your duties and responsibilities as Vice President, Insurance?

A I supervise the insurance and pensions department of GTE Service Corporation. The insurance and pensions department consists of four sections: the Corporate Insurance Section, which is concerned with the insurance matters of the corporation itself, the insurance the corporation may purchase to protect its own assets; Loss Prevention and Safety, employee benefits as group insurance, or what we call employee insurance; and pensions, savings and investments and thrift plans.

* * * *

[2-75] Q I'll ask you more about your participation in collective bargaining later. But now, moving on, Mr. Hyland, can you give the Court, if you will, an overview or summary of the various benefits that GTE provides for its employees?

A Yes. We provide a comprehensive package of employee benefits on a non-contributry basis; that is, the employees do not make any contributions toward the cost of the benefits, and they range from income continuance, survivors' benefits for life insurance, medical benefits, which include health, hospitalization, surgical, dental benefits, retirement benefits, including pension

plans, [2-76] savings and retirement plans; employee stock ownership plans and employee stock option plans.

Q Now, in particular, is there a GTE health benefits plan?

A Yes, there is.

Q Can you tell us something about that, for example, the extent to which it's a uniform plan, who it covers and so on?

A The GTE medical benefits plan applies to all of the employees employed in the United States on a uniform basis, which they're about—at least on December 31, were about 179,000—I'm sorry, about 167,000 employees.

Q It covers union as well as non-union employees?

A It covers union and non-union employees, yes.

Q Does it cover, to use Mr. Greenfield's language, does it cover the high positions, the president, down to the low positions, the sweeper?

A Yes, it covers all employees irrespective of their position.

Q And it covers, you say, approximately 167,000 of the state employees. Have you got the figure for the Massachusetts employees?

A Yes, sir. It's 7,100 employees in Massachusetts.

[2-77] Q 7,145, is that it?

A You want the exact number?

Q Yes.

A 7,145.

Q In how many Massachusetts locations?

A We have thirty locations in Massachusetts.

Q And does this GTE health benefits plan cover the dependents?

A Yes, it does.

Q What's the arrangement with respect to dependents?

A Any dependent, as we define it in the plan, is covered under the plan for the same benefits that the employees are covered. A dependent, as we define it is the employee's spouse and any dependent children who live

with the employee in a child-parent relationship, including students attending accredited colleges up to age 25.

Q Is there a contribution the employee must make?

A No. Our plans are not contributory.

Q Non-contributory?

A Yes.

Q And about how many of these dependents are covered in the United States?

A I have to kind of extrapolate. Most companies do [2-78] have approximately two and a half dependents per employee. So if we're talking about 167,000 employees,—excuse me just a moment—we're talking about approximately 584,000 employees and dependents. That would be 167,000 employees and 417,000 dependents. To that we have to add 16,000 retirees who are also covered under the plan and approximately 8,000 other employees who are on long-term disability or approved leave of absence. We have a total of approximately 608,000 plan participants in the United States.

Q Is this an insured plan?

A Yes, it is.

Q And with what company is this plan insured?

A The plan is insured with the Travelers Insurance Company.

* * * *

[2-80] Q Would you simply give the Court a short description of the various health benefits which the GTE health benefits plan currently makes available?

A Yes. In the health benefits program we include: hospitalization, surgical procedures, miscellaneous hospital charges in connection with surgical procedures, such as the rent or fee for operating rooms, supplemental accident benefits for emergency treatment in the event of an accident, mental health coverage, as well as dental benefits.

Q Now, Mr. Hyland, has GTE always followed this policy of making available to its employees a uniform health benefits plan, where all the employees receive essentially the same benefits?

A No, it hasn't. GTE as its presently constituted originated as a small telephone company that grew through acquisition and mergers of other telephone companies and other electronic manufacturing companies to the form in which it's constituted today. In this acquisition and merger process, [2-81] which took place largely in the latter 1940's and 1950's, we acquired not only several subsidiaries, but with them the various employee benefit plans of those subsidiaries. The plans were divergent in nature from one to the other, as well as being funded under different schemes, different insurance carriers. In the beginning, the very late 1950's early 1960's, there was considerable employee dissatisfaction with this arrangement, where the employees knew that other sister companies of GTE employees enjoyed a greater benefit than they might enjoy in a particular area. We had considerable difficulty in transferring management employees from one subsidiary to the other and, in fact, it had several occasions at that time where employees would refuse to accept a transfer. Because of the benefits that he received he would lose by accepting the transfer. The process of managing the employee benefit plan was considerably cumbersome. Each one of the subsidiaries had at least one, and sometimes two or three insurance coordinators, who spent their time administering the plans on a local subsidiary basis. This, of course, involved considerable cost to maintain a [2-82] staff of employees to keep track of the various benefits and to administer them in this manner.

Beginning in 1962, it was determined that GTE would be better served having a single plan for all of its employees, beginning with all of its management employees and then ending with all of its union employees, all the employees who were represented by a bargaining unit, as those plans came up for bargaining and the benefit levels were bargained for.

Q You had a process then of consolidating all of these twenty separate health benefit plans, which ultimately ended into the one—

A Into the GTE plan, that's correct.

Q —the GTE uniform plan?

A Yes. We had somewhere in the neighborhood of about twenty different plans.

Q And how long a period did this process take?

A Well, the entire process took approximately ten years, nine years. The management employees benefits were instituted immediately, and that included management employees as well as non-management employees who were not members of a collective bargaining unit. The employees who were members of [2-83] a collective bargaining unit took a considerable longer period of time in that we obviously needed to bargain their benefits for them and, in general, we have three-year union contracts. So that it took three shots, if you will, or three steps to bring the level of benefits for the various unions into a single plan. So, three contracts, three years, is approximately nine years.

Q What consequences did this process of consolidating the plans into a uniform plan have with respect to the size of your administrative staff?

A Today, I operate within my department, which is a total twenty-five people, six of those people are dedicated to the employee insurance section. Prior to our consolidation there were in the neighborhood of forty employees employed in various locations at GTE doing the same work. So, in a sense, we reduced the administrative staff to administer the employee benefit plans from about forty now to six.

Q At a consequent reduction in costs?

A Obviously, yes.

Q What consequences did this program have with respect to the employee relations in your company?

[2-84] A The complaints that we had been receiving with respect to the variance of benefits have literally disappeared. We don't receive that complaint anymore.

Q What is your percentage ratio for what you might call controversies or errors as a percentage of total claims?

A For the plan year ending 1979, the error factor—what we term the error factor—was less than 1 percent.

Q Do you have a uniform claims handling procedure nationwide, Mr. Hyland?

A Yes. There's only one procedure that's employed; there's only one form. The same form is used throughout the country for each employee. They simply complete that single form, submits it to the Travelers together with his incurred medical expenses and is paid directly from the Travelers, and there are no exceptions to that.

Q Do you have one set of instructions, claims handling instructions that are used in connection with this procedure?

A We do not. GTE only has one set of instructions and that is to give the employee the form and tell [2-85] him to mail it to the Travelers. The Travelers, however, has a set of instructions called the Claims Manual that they prepare in their home office in Hartford and is distributed to their various claims officers throughout the country that handle GTE claims. But there's only one manual.

Q When you have a uniform set-up like this, a uniform procedure, what consequence does this have with respect to the level of professional training that is needed for your claims handling personnel?

A The majority of claims, and we're estimating 98 to 99 percent of the claims that are processed, you employ a claims clerk that would require a minimal education, probably a high school education, with minimal training in the insurance business because they're processing on a routine basis the same type of claim that they see day in and day out. So that the claims processing is done at a

relatively low level, low insofar as educational requirements are concerned. We get higher level employees, higher trained employees involved in a few of the claims where errors have been committed, and on very few claims that are controverted we might have [2-86] to elevate to the level of an attorney.

Q All right, sir. Now, an incidental question with respect to the claims handling procedure in Massachusetts. GTE has a Fall River plan, does it not?

A Yes, that's right.

Q And where is it that all of the claims, the health benefit claims of the Fall River employees are processed, decided upon and paid?

A Providence, Rhode Island.

Q And with respect, on the contrary, with respect to the Salem plant of GTE where is it that the claims of those employees are processed, decided upon and paid?

A Danvers, Massachusetts.

Q Now, Mr. Hyland, to what extent has collective bargaining been involved in the formation of GTE's health benefits plan?

A I'm sorry, you said to what extent or to what respect?

A To what extent.

A The collective bargaining process has been involved to the extent of providing benefits to our employees because our employee benefits program, as it applies [2-87] to the members of the bargaining unit, is a bargaining plan. That is, it's negotiated between management and union, or the collective bargaining agent, so the union's input into that plan is taken into account, and the plan that we have is by agreement with the union members.

Q How many of GTE's operating subsidiaries have engaged in collective bargaining?

A All of them.

Q What unions are we talking about in this connection?

A We deal nationally, negotiate nationally with the International Union of Electrical, Radio and Machine

Workers, IUE, AFL-CIO. That covers substantially all of the products group or the manufacturing portion of our company. The telephone communications portion, the telephone operating companies, deal primarily with the Communication Workers of America, and in two cases, the International Brotherhood of Electrical Workers, who do not participate in the coalition bargaining of the IEU.

Q So, the IUE bargaining is coalition bargaining?

A Yes, sir.

Q What has been the typical period of years for the term of a GTE collective bargaining agreement?

[2-88] A Three years.

Q Now, as corporate insurance manager, director of insurance and now Vice-President of Insurance, have your duties and responsibilities involved you in any way with collective bargaining and health benefits?

A Yes, it has.

Q Would you describe how they have involved you?

A Yes. At the beginning, in benefit design and benefit planning we worked together with the human resources department in developing a plan that GTE is willing to bargain. When the union contract is being bargained—we're now in the bargaining process—I and my staff hold ourselves available to the persons who are negotiating at the table on a daily basis by telephone as the union and the negotiating committee negotiates any changes in the package that we might be offering or demands, a list of demands that the union has made. We, in turn, are in constant contact with the Travelers where costing of any changes of proposed benefits or demanded benefits are necessary. In situations where benefits might have become a strike issue or are a strike issue either myself or members of my staff will [2-89] actually check into the hotel where the bargaining is being conducted so that we're immediately available to the people doing the negotiation.

Q Has it been GTE's practice to bargain with respect to specific health benefits or have they, on the other hand, bargained on merely the level of monetary contributions?

A We only bargain with respect to the level of benefits; we never bargain and refuse to bargain with respect to contribution levels.

Q And that's true, in particular, or specifically of health benefits; is that correct?

A That's correct.

Q And this is true, even more specifically, with respect to mental health care?

A That is also correct.

* * * *

[2-91] Q Now, Mr. Hyland, making reference where you wish to do so to these three collective bargaining agreements, Exhibits 12, 13 and 14, would you summarize for us GTE's collective bargaining history over the last seven or eight years with respect to mental health care benefits?

A Yes. The agreement dated September 3, 1973 through November 15, 1976, there appears an amendment to the employee benefit plans that provides for [2-92] out-patient mental health services. Until this time in-patient mental health services had always been provided as part of the hospitalization program, and for the first time in 1973 we provided an out-patient benefit. Shall I read it?

Q No, I don't think it's necessary to read it. And then what happened in 1976?

A In 1976 that benefit was then improved by raising the per visit amount that was to be payable under the plan and reducing the amount of visits in any twelve consecutive months that would be permitted under the plan and defined whose services would be reimbursed under the plan; the person who was providing the services was defined.

Q Would you characterize that as an improved out-patient benefit?

A Yes, it is.

Q Incidentally, do these agreements have more scope and more applicability than the single plan that happens to be on the cover there?

A Yes.

Q The single location.

A The single location. The bargaining contract is the interior of the booklet, if you will, and that [2-93] is the same for all employees who are covered under the IUE contract. At each location we print a different cover with that location's address on it, so that each employee at that location has his own copy of the union contract. The main reason for that is that there are some variations with respect to holidays, lunchroom facilities and parking facilities and things that apply only to a particular location that don't apply to a national organization.

Q And now would you continue what happened as a result of the bargaining in 1979?

A In 1979 the benefits that had been bargained for in 1976 were extended to include dependents with respect to out-patient mental and nervous conditions.

MR. MC GOVERN: Your Honor, I'm going to place a copy of Section 47B in front of the witness, and I have also one for the Court.

Q Mr. Hyland, you're familiar, are you not, with the term mandated benefit laws?

A Yes, I am.

Q What's your understanding of that term?

A The state mandated benefit laws are where a particular state sets as a minimum standard benefits that are [2-94] to be provided under insurance contracts issued either in or outside of that state.

Q And in the course of your duties as GTE's Director of Insurance and Vice-President of Insurance are you generally familiar with the Massachusetts mandated benefits law and mental health benefits?

A In general, yes.

Q Now, do you have a copy of Section 47B there in front of you?

A I do.

Q Directing your attention to subparagraph a, about in the middle of the page, do you see where it says: "In the case of benefits based upon confinement as an in-patient in a mental hospital under the direction and supervision of the Department of Mental Health"—does the GTE health benefits plan provide benefits for confinement as an in-patient in a mental hospital under the direction and supervision of the Department of Mental Health?

A It provides mental and nervous condition benefits while confined as an in-patient in a hospital, as is defined in the summary plan description.

Q Well, would this kind of mental hospital comply [2-95] with the definition that you have in your plan? Would it always comply?

A I can't answer that it always will. In general, from reading the words I would say that probably in most cases it would. But always, I don't know.

Q If you had a licensed mental hospital that was not, however, accredited as a general hospital, would it apply?

A It might not. It may, but it might not. It may not meet other criteria or stipulations as defined in the plan.

Q Where are the criteria that you're addressing; is that on page 31? You can make reference, if you will, to the latest summary plan description, Exhibit 17.

A The latest summary plan description on page 30 defines a hospital. Shall I read that? That's 17.

Q And it's pages 30 and 31. Looking over the, I believe it is the three or four paragraphs here that define what types of hospital GTE is talking about under this plan, might you well have a licensed mental hospital under this statutory paragraph a that would not come within some of [2-96] those paragraphs?

A Yes, it's conceivable that it would not.

Q The accreditation, for example, that is being talked about at the top of page 1 is an accreditation as a general hospital, is it not?

A Yes.

Q So you might well have a licensed mental hospital that is not accredited as a general hospital?

A That's correct.

Q Do you know whether a licensed mental hospital in all cases meet the Medicare type of hospital standard that is in the second paragraph there?

A No, I do not know.

Q Are these some of the decisions that would have to be made by claims personnel, assuming the Mass. statute were applicable and others like it?

A Exactly.

Q How about the third category of hospital? Would a licensed mental hospital necessarily pass those tests?

A Not necessarily, no.

Q How would you have difficulty knowing whether it did or didn't?

A You would have to examine the services that are [2-97] being provided by that mental hospital, and if it met the conditions of the third test, coverage would then be provided. If it failed to meet those conditions, then coverage would not be provided. But, someone would have to make that determination and make that judgment.

Q Directing your attention, Mr. Hyland, back to the paragraph (b) under the statute, do you see where that seems to refer to confinement as an in-patient in a licensed or accredited general hospital; do you see those words?

A Yes.

Q Now, does the GTE health benefits plan generally cover that sort of thing?

A Yes. Confinement in a licensed general hospital for mental and nervous disorders is treated the same as any other illness.

Q Dropping down to paragraph c, skipping over the first line which has to do with the monetary level, I want to focus on that first clause that appears to relate to services by an entity called, and I quote, "Comprehensive

health service organization." Does the GTE health benefits plan provide benefits for care in an organization so described?

[2-98] A I don't know. We don't use those terms in the plan, nor in the summary plan description, and I don't know what the terms "comprehensive health service organization" really mean; they're not defined.

Q Referring again to the latest summary plan descriptions, can you tell the Court what page the basic mental health care provisions appear on?

A They appear on page 12.

THE COURT: We're still on Exhibit 17?

MR. MC GOVERN: Yes, we are, your Honor.

Q Now, I direct your attention to the paragraph under the heading, Mental Health Services, on page 12 of Exhibit 17. That does indicate that you will provide benefit coverage for a community mental health center under certain circumstances; am I correct?

A That's correct.

Q But do you see anywhere there any coverage for something called comprehensive health services organization?

A No, I do not.

Q Then dropping down to clause 2, Licensed or Accredited Hospital, does the plan cover services [2-99] by such an entity?

A By accredited hospitals, yes.

Q Well, supposing it's licensed and not accredited?

A Then it might have to meet another one of the tests under the definition of hospital.

Q Before it could clear?

A That's right.

Q Take a look at Clause 3, if you will, which is referring to, first of all, a community mental health center which is subject to the approval of the Department of Mental Health. Would services by a community mental health center be covered by the GTE plan?

A Yes, they would.

Q Would they always be covered by such a plan?

A No, they might not be.

Q What is the proviso that would have to be applicable in order for it to be covered?

A That the diagnosis and treatment be prescribed by and supervised by a licensed physician.

Q Is there anything in Section 47b that requires a recommendation by a licensed physician before you receive the benefit with respect to community mental health centers?

[2-100] A Yes. They use the word psychotherapist and then define it as meaning a person fully licensed to practice medicine, under the provisions of the act.

Q That's down below, is it not?

A Yes.

Q There's no requirement stating that before you can get coverage for going to a community mental health center you have to be recommended by a psychotherapist?

A No, I don't read that.

Q The next clause or the next entity that's dealt with in the same clause appears to be a mental health clinic. Do you provide coverage for mental health clinics?

A Yes, we do, provided they are affiliated with a hospital.

Q So, once again, you have—you seem to have a series of qualifications and so forth. Sometimes a mental health clinic might be covered, sometimes not, depending on whether there's a hospital affiliation?

A That's correct.

Q The next mental health facility that's referred to [2-101] is a daycare center furnishing mental health services. Does the GTE plan provide a benefit with respect to services in daycare centers?

A I can't categorically answer yes or no. I'm not sure I know what a daycare center is, with respect to mental health insurance. I've not heard the term before.

Q You don't see any definition as such in 47 pages?

A No, it's not defined on what I have in front of me.

Q All right, then. Moving on to services rendered by a psychotherapist as defined in Section 47b, does the GTE plan cover services of this type?

A Yes, it does.

Q Can you elaborate on that?

A By virtue of the definition of a psychotherapist as being a fully licensed—a person fully licensed to practice medicine, our plan requires that the person be a licensed physician. So I can interpret a person fully licensed to practice medicine as being a duly licensed physician.

Q All right, sir. Now, moving on to this one last form of service, namely by a psychologist licensed under a particular chapter. Does the GTE plan provide coverage for services of that sort?

[2-102] A No, it does not.

Q Whether licensed or not?

A That's correct.

Q What are the reasons why GTE does not provide services for licensed or unlicensed psychologists?

A Primarily, it's a problem of definition and qualification. There's several states that have different qualifications for licensing psychologists. Some states have fairly rigorous educational and testing requirements in order to obtain a license and a rigorous test that has to be passed. Other states have that to a lesser degree, and some states not at all. In order to maintain the uniformity of benefits, we've had to provide fairly rigid definitions under the plan so that they apply to all of the employees uniformly. And because of the divergence in several states of licensing practices and qualifications, we find at this point in time we're not able to recognize psychologists as a class under the plan as we offer, for example, licensed physicians because we are familiar with what a licensed physician is and the requirements to become a licensed physician.

Q Stepping back a minute, Mr. Hyland, based on your [2-103] duties as Vice-President of Insurance and so forth, would you tell us what effect do you see a statute such as 47b and others like it having on your GTE health plan, on the administration of it?

A It would severely complicate the administration of the plan in that, if we're dealing with fifty-one jurisdictions, we would have to have at least fifty-one variations to a single plan. The problems in administration would then be multiplied perhaps not be fifty-one but by a significant factor.

Q Whatever number it is, it's—

A It's more than it is now, yes.

Q —undercutting the uniformity you now have?

A That's correct.

Q What else?

A We think it would probably lead to severe employee dissatisfaction that we had experienced in earlier years that we endeavored to overcome by designing a comprehensive package of benefits that we now have that the employees can enjoy. If we had divergence of benefits from one state to the other, we would simply lose the benefit that we arrived at [2-104] by having a uniform plan.

Q What about administrative costs?

A They obviously would go up. The more complex you make the plan, the higher degree of expertise is required to administer the plan, so we would immediately required higher talented, hence higher pain employees, and if you multiply the complexity by the numbers of units as in the fifty-several states, you then have to add additional staff of that caliber in order to cope with the various divergencies between the several states.

Q What would be the effect on the level of benefits available for employees?

A One of the effects is that the level of benefits would not increase at a rate that is desirable to keep the plan competitive with our employees and for the benefit of the employees. If the level of benefits had to increase, then some other area of the wage benefit package would have to be reduced, such as cash wages or possibly a

holiday would have to be give up or some other benefit. There's a cost trade-off somewhere.

Q I'd like to focus a little more on one of those effects you just mentioned, namely the effect of [2-105] this statute and others like it on GTE's administrative costs. Can you explain more fully to us the types of administrative problems that these statutes would raise that produce more time, most costs, more error and that sort of thing?

A Yes. The mere complexity of having to deal with fifty sets of criteria, if each of the states took similar action, would require a person who was familiar with first the requirements of the several states. We'd have to inquire of the employees where his residence—of course, we know where the employees reside and where they work—if it's a claim for the employee's dependents, where they reside should there be a difference between the states between which the employee is working and residing and if one state on one side of the border may provide benefits for residents where the one across the border may require or provide benefits only for people who work in that state.

Q Before we get into that, let me backtrack with you for just a minute. Before the problem that you have in determining the eligibility, and that sort of thing, is there a problem about finding out [2-106] what the laws are as you go along week after week?

A Well, more surely there is. At the moment, we're operating under the federal statute, the ERISA statute, and we can identify that and know how to operate under that comfortably now. If we were subject to fifty different laws with respect to employee benefits, we would then need legal counsel in fifty of the several states, for each of the several states, in order to keep us up to date with respect to the changing benefit requirements of those states.

Q Let me digress just a minute, less than a minute. Do you have a savings investment plan?

A Yes, we do.

Q What is it anyway?

A The savings investment plan is a matching contribution plan whereby the participating employees contribute a portion of their salaries and the company matches fifty cents on the dollar for each dollar that the employee contributes. And at the moment, the employee may invest his contributions in either GTE shares, into a shares fund, an index fund, a bond fund, or a guaranteed income contract.

Q Maybe I'm using the wrong term, but don't you have [2-107] a plan where the employee is enabled to borrow money—

A No, this is the same plan we're speaking about.

Q Is that plan subject to the laws of only one state?

A Yes, it's the loan provision that you're making reference to. We're amendnig the plan January 1 of 1981 to provide or enable the employees to borrow funds from the plan, as opposed to have in-service withdrawals and incurring penalties. When we were designing this loan provision of the plan one of the first questions that was raised were what usury laws would we be subject to, and the instructions I was given by my supervisors were that, if we were subject to the usury laws of several states, to forget the benefit; that we would not go to the expense to provide the administrative procedure to keep up to date with all of the usury laws.

Q It turned out you're going to have this plan because there's just one single law?

A Yes. Now that we've obtained opinion of counsel that because the trust is domiciled in Massachusetts and the loan is going to be made in [2-108] the State of Massachusetts, that we're subject to Massachusetts banking laws and having, now being subject only to one state banking law, we're proceeding to introduce that benefit. And we'll have that on January 1.

Q Getting back to health benefits again and away from the digression about the somewhat similar situation of this other plan and what would happen if you had a series of conflicting laws, you mentioned the monitoring difficulties and costs. Now, I'd like you to talk a little more about the additional difficulties and costs that would be associated with determining eligibility, dependents, residents, where you work, divorces, this sort of thing.

A The way the states thus far, to the extent that I'm familiar with the few states that have enacted such legislation, define eligibility is various. Some states define a person is eligible for a mandated benefit as being employed in the states, others residing in the state, and others residing or employed, and still others possibly employed and residing. The first thing that would have to be determined when a claim is received by [2-109] the claim clerk is to determine if the employee is eligible to receive benefits under that claim. Where we have the divergence of definition of eligibility, the claim clerk is then going to have to inquire as to the residence and employment status of the employee or his dependent, and then apply the correct interpretation to the state statutes that apply in order to determine under which statute he may be eligible to receive the benefit.

Q As you complicate the form and as you complicate the claims handling procedure, what happens to your error ratio?

A It obviously would have to go up.

Q What happens to the necessity to instruct your claims handling personnel?

A The higher degree of training required, a higher degree of instruction required and a higher degree of supervision required to assure, as best you can, a low level of error factor.

Q What effect cost-wise does this kind of mandatory statute and others like it have on the task that the company has of informing employees of their benefit rights?

[2-110] A As Mr. Morris testified, we're required under the Pension Reform Act to provide every plan participant with a summary plan description which is a layman's version, if you will, of the summary of the salient features of the plan. We now print a summary plan description of our plan which is Exhibit 17. The way we physically produce the summary plan description is everything is printed. One shot and it's all the same. The only difference being, again, the cover, the same as we do on our union contract. So we're able to produce—in fact, last year we were able to produce half a million of these, 500,000 of these summary plan descriptions, but it was a one set-up and then print 50,000 (sic) of them. The cost is approximately $3 for one of these booklets. If we were to produce, for example, 50—if we had fifty several states with such enactment—the cost would be increased, we're guessing, to approximately $5 a book. There is the possibility of not printing fifty different versions of the same booklet with the state exceptions but print one booklet and then have in the back, for example, a state exception sheet. We find that would be undesirable from an employee's [2-111] point of view in his ability to understand what his benefits are because you would be explaining the benefits in the front and have possibly taking them away in the back, which is contrary to proper communication.

Q In terms of this company's experience in the 1950's and 1960's, how would you characterize overall, the effect of this Massachusetts statute and others like it on the GTE plan?

A Well, the effect is to bring us back to where we were in the 1950's, with a multiplicity of plans not necessarily having a relationship one to the other, which would generate increased costs and severe employee relations problems.

Q From your standpoint, its turning back of the clock?

A Yes, it is.

MR. MC GOVERN: No further questions.

THE COURT: Let me ask you this, sir, if congressional policy—the Congress of the United States, in other words—if their policy changed to the extent that there was a national congressional health policy similar to our statute, the Massachusetts statute, included in [2-112] ERISA, okay, would that be troublesome to you?

THE WITNESS: No, sir.

CROSS-EXAMINATION
BY MR. MONTGOMERY:

Q Just to follow up on the Judge's question, Mr. Frank (sic), is it fair to say that you're not opposed to mandated benefits, just to diversity of the requirements of the mandated benefits?

A That wasn't his question.

Q I understand that. I'm asking a different question.

A No, no, I'm personally not opposed, nor is GTE opposed to mandated benefits to the extent that they're reasonable and are socially desirable and for the benefit of the community as well as the employees. I think there's a resistance to mandated anything, benefits or otherwise. We at GTE like to pride ourselves, and I personally, individually pride myself in not having to be told what needs to be done but rather taking the initiative and doing it with the spirit of the free enterprise system, if I may.

THE COURT: I've asked a question, which I think is the first time I've asked a question—it may be appropriate—we'll take a [2-113] short recess, five minutes.

(Recess)

Q Mr. Hyland, I just want to clear up one possible discrepancy from your direct. You did testify, I think, that the exhibits marked as 12, 13 and 14, the collective bargaining agreements, were standard for all employees but the covers are different.

A All employees who are covered by that union contract.

Q But there are differences for, you mentioned, for holidays and things of that nature?

A There are differences on the local level, in dealing with the local.

Q And are these contained in the documents that are marked as Exhibits 12, 13 and 14?

A Yes. The differences that apply to the Long Avenue plant are in those particular ones. The ones that would apply to the Ipswich plant would have possibly variances with respect to holidays and things of that nature.

Q And holidays is an example of the kind of benefit [2-114] under the agreement that would vary from state to state?

A Yes. In fact, they might vary from plant to plant and community to community.

Q You also mentioned lunchroom facilities as a variation. Would you elaborate on that, if I'm correct in my recollection?

A Yes. Some plants have lunchroom facilities, others do not. Where lunchroom facilities are provided the employee, in some cases they're subsidized and others not. And in particularly the case of subsidies for the lunch or cafeteria facilities, sometimes those are bargained.

Q Are you familiar with any state or local laws in any state of the country which require lunchroom facilities?

A I'm aware of the existence of such laws. I'm not familiar with any of them.

Q But, would it be fair to say the individual agreements would comply with those various state and local requirements?

A Yes.

Q Are there any other variations besides holidays and lunchroom facilities that may differ from [2-115] bargaining unit to bargaining unit or state to state or plant to plant?

A Yes. Work rules—

Q What do you mean by "work rules"?

A How many employees are to be employed on a particular line. For example, what the bidding process is for first-line supervision or for another job. It could be any variety of different work rules. Sometimes, well, there's a variety of them.

Q Now, do you know what percentage of the premium, the total health care package premium, is attributable to claims for treatment for mental or nervous conditions?

A I can tell you the number. The premium this year is approximately $200 million. The premium for outpatient mental and health services is $2½ million this year. So, what is that, one-tenth of 1 percent, or 1 percent?

Q 1 percent.

A 1 percent.

Q Now, in the course of your duties as Vice-President for Insurance are you familiar with Worker Compensation laws?

[2-116] A Yes, I am.

Q Would you explain briefly how the worker compensation system works nationally?

A There is no national worker's compensation system. Several states have jurisdiction over worker compensation laws within those states.

Q And do you have, does GTE have a relationship with a particular insurance carrier?

A Yes, we do.

Q Is it one carrier?

A One carrier provides all of the worker's compensation benefits, except in those states where a state fund is mandated.

Q And how many states do not mandate a fund and therefore require you to insure your worker compensation benefits?

A Well, there's eight states that mandate it, so there'd be forty-two states and the District of Columbia that do not.

Q And you have one carrier for those forty-two states and the District?

A That is correct.

Q Who is that carrier?

A It's Lumberman's Mutual Insurance Company—[2-117] Lumberman's Mutual Casualty Company.

Q Do you have a single policy with Lumberman's Mutual?

A Yes, we do.

Q And does that policy comply with the individual requirements of each of the forty-two states plus the district?

A Yes, it does.

Q And how does it do that? The benefits obviously vary.

A With a great deal of difficulty, I'd say. The policy is a single policy, and it has attached to it the state exceptions. Each of the state exceptions is larger than the policy itself, so that emerging policy is literally about 6 inches wide. It takes up two three-ring binders. The administration of the worker compensation benefits are not overly complicated in that we can always identify the employee's workplace, so we know in most cases what jurisdiction applies in a worker's compensation injury situation. What complicates the situation is the variance of benefit from one state to the next and the application of such benefits. It does give rise to inequities between [2-118] one employee and the other, which is a situation that we simply have to explain to the employee that that's just the way it is.

Q And for how long has GTE provided state specific benefits in those forty-two jurisdictions plus the district on the worker's compensation?

A Since worker's compensation statute were enacted in each of those states.

Q And how long has that—well, I guess you couldn't state for each of those states—

A It was before I was born, I can tell you that. And it's more than fifty years.

* * * *

[2-120] Q Now, do you know how many states currently mandate the inclusion of mental health benefits for treatment of mental or nervous conditions in group insurance policies?

A I know of three and I suspect a fourth and there may be, perhaps, fifteen or twenty.

Q Now, are the three with which you're familiar, do those statutes require that the benefits be provided for contracts—extraterritorial, for contracts issued outside of the state covering in-state workers and residents?

A Two of them do, and the third one, I'm not certain.

Q So that it would be your understanding it would only be those two statutes that the company would be required to comply with, with respect to any policy not issued within those two states?

[2-121] MR. MC GOVERN: Excuse me. Objection. I think he was not certain of the other one.

THE COURT: I agree with you. I think he was not certain.

Q Maybe we could identify the states. What are the two states that you are certain?

A Maryland and Massachusetts.

Q Would it be fair to say that the only current problem presented for the GTE plan by the mandated benefits statute are presented by those statutes that have an extraterritorial effect?

A No, that would not be fair to state that.

Q Why not?

A Well, the extraterritorial effect is not the most complicating issue. The more complicating issue is the—may I ask, perhaps, to clarify what we mean by extraterritorial? Do you mean extraterritorial, as respect to the contracts issued within and outside of those states?

A Yes. In other words, there are—correct me if I'm wrong—there are statutes which provide or mandate

minimum mental health benefits but which do not apply, which apply expressly only to contracts issued in that state?

[2-122] A Yes. With respect to contracts issued within or outside of a particular jurisdiction, doesn't present me with a particular problem because it doesn't affect the delivery of the benefits within the state.

Q That's right. So that your answer to the question would be that the problem—you talked about problems of administration, and I'm just trying to make sure that your testimony is clear. The current burden imposed by mandated benefits statutes is only imposed by those statutes, however many there are, that have what we call an extraterritorial effect?

A Yes.

Q Now, do you have any actual data, any studies that you performed that would indicate the extent of the administrative burden that is imposed by that statute, by those statutes?

A No, I do not.

Q Do you have any data that would indicate the extent of the total administrative costs of the GTE health plan?

A Yes, I do.

Q What is that?

[2-123] A The cost is—

Q What percentage or dollar figure?

A The cost is approximately 6 percent of the premium.

Q Now, with respect to that portion attributable to administrative costs, what further portion is attributable to costs of administration for claims for treatment of mental and nervous conditions?

A I'm sorry, I don't know that. For a fast answer, we would simply prorate the claims which we do know over the cost and say that's it, but we don't know that that's it or not. As a matter of clarity, if I may, GTE does not administer the plan; the Travelers administer

the claims for us, and they charge us at the rate of 6 percent of the premium for that administration. So it's their administrative expenses that we're addressing.

Q A couple of more questions, Mr. Hyland. You're familiar, are you, with the federal statute which requires employers to provide for pregnancy-related disabilities on the same basis as other disabilities?

A Yes, I am.

[2-124] Q And are you aware that prior to the effective date of the federal amendment to Title VII last year that there were various state requirements—

A Yes, I am aware of it.

Q —mandating those benefits?

A Yes, I am.

Q Are you aware of a particular Massachusetts requirement in that connection?

A No, I'm not.

Q Prior to the effective date of the federal statute, what was the extent of benefits provided for pregnancy-related disabilities in the GTE plan?

A We provided no disability coverage with respect to maternity.

Q And I assume that now you do provide those benefits in accordance with the federal statute?

A That is correct.

MR. MONTGOMERY: Thank you. No further questions.

THE COURT: You had no benefits at all?

THE WITNESS: For disability. We provided medical reimbursement for obstetrician and hospital, but no loss of wages.

THE COURT: Thank you very much.

[2-125]

REDIRECT EXAMINATION
BY MR. McGOVERN:

Q Mr. Hyland, at the outset of your cross-examination, you said something to the effect that you weren't against or weren't opposed to mandated benefit laws, except that you do have a reservation that you would prefer to do these things yourself. Do you recall saying something to that effect?

A Yes.

Q When you were talking about this reservation, were you thinking in any sense of the collective bargaining process?

A Most specifically in respect to the collective bargaining process.

Q Can you explain just exactly how important that reservation is?

A Yes. We bargain in good faith with the employees who are represented by a collective bargaining agent. And we don't attempt, and never have, nor will we, to impose upon those employees a benefit that they have not, in fact, bargained for, nor, obviously, will we take a benefit away from them. It's important to us as employers, and I think equally as important to the employees, as members of this collective bargaining arrangement to come [2-126] to an agreement on the benefits and wages and working conditions and everything else that are part of the bargaining contract. I think—while I've never belonged to a union—I suspect that employees who do belong to a union feel a certain amount of pride with the thought that they may have something to say about their own destiny and about their own employment through the bargaining process. So that primarily is an important thing that should be left to the free enterprise system, if you will, private bargaining between people who know what they're doing.

Q This is the area reserved for the collective bargaining process?

A Yes, it is.

* * * *

[2-128] Q Mr. Hyland, very recently, has there been a presidential commission to study the operation of the Workman's Compensation laws in America?

A Yes. The President convened a commission called the President's Commission on Workman's Compensation, appropriately enough, in 1974.

Q Have the inequities of the way these compensation laws are working out for employees, did that have anything to do with the establishment of that commission?

A That was the primary motivation of the establishment of the commission.

Q Have the costs and the inefficiencies of the program as it's working out, was that a subject matter of that commission?

A Yes, it was.

* * * *

[2-131]

[TESTIMONY OF JOHN G. LARSON]

DIRECT EXAMINATION
BY MR. GREENFIELD:

Q Will you please state your name and address?

A My name is John G. Larson. My address is 10400 Melissa Mill Road, Richmond, Virginia.

Q Could you give us your academic background starting with college?

A I graduated from the University of Richmond with a Bachelor's of Science in Business Administration. I received a Master's in Hospital Administration from the Medical College of Virginia. And I received a Ph.D. in Health Administration from the University of Manchester in Manchester, England.

Q When did you receive your Ph.D.?

A 1975.

Q What is your present position?

A I am currently an Associate Professor in the Department of Health Administration at the Medical College of Virginia, Richmond, Virginia.

Q Have you published any studies in the area of mandated health insurance coverage?

A Yes, I have. I have published a study called Mandated Health Insurance Coverage, a study of review mechanisms.

Q And when did you publish that?

A This was released in 1979.

Q At whose request did you publish that?

A I conducted the study for the Bureau of Insurance in the State of Virginia, really at the behest of a commission called the Health Care Cost Containment Commission in the State of Virginia. The Bureau of Insurance was acting under the direction of this commission and the Bureau of Insurance requested [2-134] that I do the study.

[2-143] Q Now, in the course of preparing your report did you formulate any opinion as to the cost of mandated benefits for covering chiropractors in Virginia?

A Yes, I did.

Q And is that referred to in your report?

A Yes, it is.

Q Is that referred to in approximately pages 35 and 36?

A Yes, I believe it was on page 35 that I make the statement of trying to get an estimate of what the cost is in the State of Virginia. The reason I did this was there was simply a lack of real accurate or just simply available data. Often in the discussions over the feasibility of a mandated [2-144] benefit, cost impact is constantly brought up. Too often, the figures are provided as simply, as you will see on page 35, as an estimate of what the monthly increase might be for a single policy holder. For instance, they stated here in the State of Colorado it was $.26 per month.

Q You're referring to page 36 here?

A Right. Also, it's stated on page 35. What I tried to do was to demonstrate the magnitude to the entire state, or if you like, those who have to pay the bill, meaning employers or employees, of what the entirety might be, the total impact of just a $.26 per month premium.

And so simply, what I did there to demonstrate that in a very crude fashion, but the only way available really, was to multiply that $.26 times the number of Blue Cross Blue Shield subscribers in the State of Virginia. That yielded a figure of approximately $11 million annually. That did not include those covered by commercial insurance. I merely used Blue Cross plan subscribers because I was essentially using a Blue Cross plan figure, if you like, in Colorado. It's a very crude estimate, but again, trying to give an estimate of the totality of the impact. [2-145] Q Now, you did it by figuring out the cost of the particular benefit per individual within the group referred to?

A Which is given on page 36.

Q So the answer to my question is yes?

A Yes.

Q And then you multiplied that by the number of people within that group?

A In the State of Virginia, yes.

Q And you said in your report, you said on the stand that it's a crude estimate?

A Yes.

Q Is there any way to come up with a better estimate?

A Yes, but the data's not available.

Q I mean on available data is there any way to come up with a better estimate?

A Not really, no.

Q And while it's a crude estimate, is it a conservative estimate?

A Yes.

Q And that conclusion about the $11 million to cover chiropractors for Blue Shield and Blue Cross subscribers in Virginia, that was submitted to the legislature?

[2-146] A Yes, as part of this—it's contained with this report.

Q Now, could you explain in somewhat greater detail what is contained on page 36 of the report?

A Page 36 is an itemization of various mandated benefits or types of mandated coverage. This again are

the figures submitted to me by the Colorado Blue Cross plan. It simply breaks down what would be the additional monthly premium expense for each of these benefits, and, again as you will see there, page 36, it also categorizes it according to individuals or single premium versus family. There's approximately I believe sixteen benefits there.

THE COURT: Approximately what, sir?

THE WITNESS: Sixteen benefits, I believe, are listed there.

Q Would you turn to page 94 of Exhibit 18, Appendix C, and would you explain to the Court what Appendix C is? The Appendix itself actually begins on page 95.

A Appendix C is a reference that I used in my study. It is a document that was passed on to me by the State of Maryland. It is a document that was [2-147] prepared by the Blue Cross plan of the State of Maryland, and it's submitted to the Economic Matters Committee in the State of Maryland. At that time the Economic Matters Committee was studying the issue of mandated health benefits. This was simply one document that was prepared I think by Mr. Fred Gloth who I think is Vice-President of the plan, who was the individual who made an oral presentation and then handed this document in with that particular testimony. The document itself simply shows that at that time there were eighteen different health mandated benefits in the State of Maryland which had been passed. Mr. Gloth's document here, or Blue Cross of Maryland, simply itemizes per mandated benefit what would be the incremental or the additional premium expense for each of the benefits.

Q And by the incremental expense you mean the expense to give that portion of the benefit which has not previously been provided by the insurer?

A That is correct.

Q Now, have you formed an opinion concerning the potential cost impact of mandated benefit laws on a nationwide basis?

[2-148] A Yes, I have.

Q On what is that opinion based?

A Well, one opinion I have clearly is that there will be a continual expense—

Q No. The question was: On what is that opinion based?

A On the data, particularly in my study, the attendance at various legislative hearings that I have participated as an expert witness, hearing other experts testify in terms of their experience as employers or insurers, and I guess the review of documents, and so forth, that I've had a chance to see.

Q And by the data, are you referring to the Colorado data that's set forth on page 36?

A Yes.

Q And to the Maryland data that's set forth at the beginning of page 95?

A That's right.

* * * *

[3-19] Q Now, based upon your review of the report to the Virginia Legislature, Exhibit 18, and based upon your review of the Factbook and, in particular, those pages identified, and based upon your review of the two Sourcebooks and, in particular, those pages [3-20] identified, based upon your review of the literature related to mandated health benefits in general and based upon your review of the literature relating to health costs and based upon your review of the literature relating to the cost of mandated health benefits, in particular, and based upon the research you conducted in preparing Exhibit 18, based upon your interviews with insurers, providers and employers, Blue Cross and Blue Shield, and based upon your attendance at various legislative hearings concerning mandated benefits, have you formed an opinion concerning the potential cost impact of mandated benefit laws on a nationwide basis?

A Yes, sir.

Q What is the magnitude of that cost impact?

MR. MONTGOMERY. Objection.

THE COURT: What's your objection?

MR. MONTGOMERY: Your Honor, it strikes me that the question is being what mandated benefits, mandated benefits where? Generally, the question is insufficiently precise to generate an answer that's really relevant to the case.

THE COURT: I think it's a perfect [3-21] question. It couldn't have encompassed much more, unless he wanted to encompass part of the building. It's a fine question, well prepared, and he can have it. You can answer.

A Yes, I have formed an opinion.

Q And what is that opinion?

A My opinion is that the nationwide impact of mandated benefits could be within the range of additional premium expense on a national basis of somewhere in the realm of $2 billion or up to $5 billion dollars.

Q Now, could you describe in general the methodology that you employed in reaching those figures?

A Yes, sir.

Q Would you please do so?

A Yes. What I did was, first of all, take additional premium expense that was provided to me in the course of my study for the State of Virginia, that is on pages 97 to 100, that gives what was the documents submitted by the Maryland Blue Cross organization that gave additional premium expense for a number of mandated benefits. And on page 36 of my study, again, there is a list that was submitted to me by the Colorado Blue Cross plan [3-22] that gave a list of additional premium expense per a number of mandated benefits. What I did with each of those sets of figures was prepare two separate estimates of the potential national cost impact and simply multiply those figures times figures that I derived from the two Sourcebooks and the Factbook and multiplied those additional premium expense times national group enrollment figures, that is, for health insurance, purely group enrollment. What I tried to do was eliminate individual policies and any self-funded programs so I could come up with a pure figure, if you like. The reason I did that is primarily that mandated benefits

are more likely to impact on group enrollment programs and not so much because the laws do vary in individual programs and at the same time make it a conservative estimate—be as conservative as possible in terms of keeping it right down to pure group enrollment figures for health insurance.

Q Now, we'll get into the specifics of your computation in a minute, but the procedure that you described, is that the same methodology that you applied on pages 35 and 36 of Exhibit 18 when [3-23] you estimated for the Virginia Legislature the cost of mandated coverage for chiropractors in that state alone?

A Yes, sir. What I did there for the State of Virginia was to simply take, in fact, one of the additional premium expenses from the Colorado figures and multiply those times the number of Blue Cross-Blue Shield subscribers in the State of Virginia; that was only Blue Cross-Blue Shield subscribers, But, essentially, the same kind of logic I employed there is, in fact, what I have done for the potential nationwide impact figures.

Q Now, I'd like to ask you some questions concerning the analysis that you did with respect to the Colorado figures. That analysis was on the assumption that other states would enact the same mandated benefit laws as Colorado; is that correct?

A Absolutely.

MR. GREENFIELD: I'd like to mark as Exhibit E for Identification a table—I'll set up a chart—a table entitled, Nationwide Additional Annual Premium Costs of Mandated Benefits, based on the Colorado Experience of Blue Cross-Blue Shield.

(Table, above-referred to, marked Exhibit E for Identification)

[3-24] Q Now, focusing on the Colorado data which appears in your report to the Virginia legislature, would you describe the analysis that you performed in reaching your opinion relating to the nationwide cost of mandated benefits?

A Yes, sir. If I could refer to the display you have over there—

Q And that is Exhibit E for Identification.

MR. GREENFIELD: May we stipulate that?

MR. MONTGOMERY: Sure.

A Okay. The item A there, which shows a dollar figure of $91.80 is simply taking from page 36 in my study, taking the additional—adding up all the additional premium expenses for the sixteen benefits under the single or if you like individual column. Those were monthly additional premium expenses, so I simply took the total of that and multiplied it times twelve, and that is where you get the $91.80.

MR. GREENFIELD: Does your Honor have page 36 of Exhibit 18?

THE COURT: I just looked at it a few moments ago. Do you want to refer to it again for some reason?

[3-25] MR. GREENFIELD: No, I want to make sure that it's clear. I think it is clear what was done.

THE COURT: Yes.

Q You added up the figures on the lefthand column which was the individual costs—

A That's right.

Q —and that was the monthly additional premium?

A Right.

Q And you multiplied that by twelve?

A To get an annual figure.

Q Why did you use that column instead of the column next to it for family costs?

A Well, I was attempting to be as conservative as possible because I'm trying to get a nationwide impact figure and I wasn't always sure whether the family figures may risk overstating it, so I figured that the best thing to do was simply use the lesser number, the individual policy holder.

Q Had you used the other number, the figure would have been higher, correct?

A Absolutely.

Q Now, would you go ahead and explain the [3-26] computations insofar as they relate to the Colorado data?

A Yes, sir. I took the A figure which is the $91.80 and B is the number of individual employees nationwide with group hospital coverage. The reason I have individual employees as the key word is because, again, the premium that was presented in A, that figure essentially is related to a single policyholder or another way of saying that is an individual policyholder. So, I wanted to use, if you like, the enrollment figures to be like or similar to where the dollar figures are derived. So, what I did there with the help of the two sourcebooks and the factbook derive a figure of number of individual employees under a group enrollment program, under both commercial insurers and Blue Cross-Blue Shield organizations. As I stated a little earlier, at the same time that figure represents a deletion of those persons covered as individual policyholders as opposed to group policyholders. I'd also deleted self-insurance programs, or another way of saying that is ASO's, which give the $55,015,000 nationwide enrollment figures.

[3-27] Q And in doing that you used what was previously described as the sourcebooks and the factbook?

A Yes, sir.

Q Go ahead. I interrupted you.

A C is nothing more than a combination of multiplying A times B, that premium amount, the $91.80 times the estimate of group enrollment with hospital coverage, the $55 million, which yields a product of about $5 billion dollars.

MR. GREENFIELD: Your Honor, I would like to offer Exhibit E into evidence.

MR. MONTGOMERY: No objection, your Honor.

THE COURT: That will be Exhibit 22.

(Document, above-referred to, marked Exhibit No. 22)

MR. GREENFIELD: I'd like to mark as Exhibit F for Identification a table entitled, Nationwide Additional Premium Cost of Mandated Benefits, and says directly

underneath that, Maryland Experience of Blue Cross and Blue Shield.

(Document, above-referred to, marked Exhibit F for Identification)

Q Now, utilizing Exhibit F and focusing on the [3-28] Maryland data in your report to the Virginia legislature, would you describe the analysis that you performed in reaching your opinion relating to nationwide costs?

A Yes, sir.

Q And would you do so, please, now.

A What I have done there in the chart—if I can refer to the chart over there—is based on in my report pages 97 to 100, and those pages are the document that was submitted by the Maryland Blue Cross to the Maryland legislative group. What was contained in that document was eighteen mandated benefits that had been passed in the State of Maryland, and along with that was a figure for additional premium expense for each of those items. They stated in the document, which is A on your display there, that the additional premium costs under the Blue Cross or hospital coverage was $23,500,000.

Q That's within the State of Maryland?

A That is correct.

Q And that figure came from Exhibit C in your report to the Virginia legislature?

A Yes, sir. On the B is the number of covered persons [3-29] which, again, in that document that the Maryland Blue Cross people had prepared, they stated that the number of covered persons was 1.5 million persons. C—

Q And that again comes from Exhibit C of your report to the Virginia legislature?

A Yes, sir. C is using the figures presented in both A and B. What I was trying to do there was get a per-covered person, or unit cost if you like, for the total of all the benefits according to the covered persons. So what I did there, essentially, is divide A, which is $23,500,000 by B, which is 1.5 million persons, and came out with a

unit figure of $15.67. D was essentially the additional premium cost for medical coverage or within the Blue's language—that's Blue Shield, essentially covering physician or medical coverage. Again, the document states that the additional premium cost was $3 million dollars.

Q That is from Exhibit C to your report to the Virginia legislature?

A Yes, sir. E is taking again the figure of numbered covered persons of 1.5 million and dividing the $3 million by the 1.5 million, which [3-30] yields a unit figure of $2.

Q And that was a per-person cost in Maryland?

A Yes, sir, for the medical coverage.

Q Will you continue, please?

A Yes. The nationwide projection, as I moved down to F, which is—F, first of all, is the number of persons nationwide with group hospital coverage. That again is a combination of individuals with group hospital coverage under the commercial insurers as well as all the Blue Cross-Blue Shield plans throughout this country. That is a figure that I derived from using the sourcebooks and the factbook, coming out with a total of 135,942,000. G is the national additional premium costs of mandated benefits for group hospital coverage. Simply what I did there is taking that number of persons with group hospital coverage, the 135 million, and multiplying that times the $15.67, that unit figure which is C times F. That yields a figure of approximately 2,134,000,000 figure. So that would be a national impact for purely group hospital coverage. Now, I'll move on to H. H is the number of persons nationwide with group medical coverage. That relates, essentially, to [3-31] the Maryland figures the Blue Cross organization, which predominately offers medical coverage or physician's expense coverage, is another way of saying that. Again, I worked at developing a figure that the number of covered persons—that is, covered persons—I should make the distinction, as different from covered employees because covered persons is essentially employees plus their dependents. So there's a greater number. The reason that is different in the two

displays is because the data I had from Maryland essentially dealt with covered persons. That data I had from Colorado was essentially individuals or individual employees, so I wanted to minimize any distortion of that data. So here, I have number of covered persons nationwide with group and medical coverage. Again using the sourcebook and the factbooks, I came out with a figure of 129,308,000. I, the nationwide additional premium cost of mandated benefits for group medical coverage, is essentially multiplying E times H. E is that unit figure of $2 per covered person that I got out of the Maryland calculations, and multiply that times the 129 million which is the nationwide estimate of [3-32] individuals covered by group medical coverage. That yielded a figure of 258,616,000. G is an addition of G, which is the nationwide estimate for group hospital coverage, and I, which is the nationwide estimate for group medical coverage, which gives a figure of approximately 2,388,827,000.

MR. GREENFIELD: I would move Exhibit E into evidence as Exhibit 23.

MR. MONTGOMERY: No objection.

MR. GREENFIELD: Excuse me, your Honor, that was Exhibit F for Identification.

(Document, above-referred to, marked Exhibit No. 23)

THE COURT: There was no objection?

MR. MONTGOMERY: No objection.

Q Could you explain the differences between hospital coverage and medical coverage?

A Yes, sir. Would you like me to explain it?

Q Yes, please.

A Hospital coverage generally refers to the insurance coverage that pays for the expenses of receiving treatment in an in-patient facility or a hospital. It can also be expanded almost, again, it depends on every benefit program of the insurance company, [3-33] but any essentially institutional services or institutional fees that might be provided to an individual.

Q Now, based upon the sources that I previously mentioned, do you have any opinion as to what the nationwide cost of the existing mandated benefit laws is?

A Yes.

Q What is that?

A That existing benefits could be within the realm of that $1.1 billion dollars.

Q And that's in addition to premiums paid without such benefits? That's with the excess mandated?

A That's essentially of existing premium dollars nationally; that would be the amount that could be considered to be the cost of state mandated benefits as an estimate.

Q Now, how did you arrive at that opinion?

A What I used is a figure submitted by the Director of the Civil Service Commission at a congressional hearing in which this individual stated that of the current premium dollar volume under health insurance benefits within the federal employees program, that 5 percent of that volume could be [3-34] considered the cost in his estimate of the cost of state mandated benefits. So what I did there was to go to the sourcebook and find out what was the most current premium dollar volume for all health insurance in this country, which is approximately $23 billion, and multiply that times 5 percent, which is the Director of Civil Service Commission's estimate, which yields a figure of approximately $1.1 billion dollars.

Q Now, have you ever heard the term self-insurance?

THE COURT: I want to make sure I understand the question. What was the exact question, if you would; do you remember the question? I think I have it, but I just want to make sure.

MR. GREENFIELD: The question was, in substance: What is your opinion concerning the existing cost of mandated benefits. And then the second question was: How do you arrive at that opinion.

THE COURT: So the basic question was existing cost, presently, I would assume, of mandated benefits, state benefits.

MR. GREENFIELD: Yes. The earlier [3-35] questions assumed that other states would do what Maryland and Colorado does. This question assumes nothing; it just states the statistics.

THE COURT: The actual statistics, or at least his estimate of them. Okay.

Q Now, have you ever heard the term self-insurance or self-funding?

A Yes, sir.

Q What do they mean?

A My understanding of self-insurance or self-funding is when an employer, or possibly a union takes on the responsibility of—and I assume we're talking about health insurance—that the employer or the union takes on the responsibility of paying for claims within its employee group out of its own financial reserves. Or maybe another way of saying it, simply not going out and buying insurance to cover those claims or expenses of its employees.

Q And I think previously you used the term ASO; do you recall?

A Yes, sir.

Q What is ASO?

A ASO stands for administrative services only. [3-36] Typically, what that refers to is where an employer may be self-insuring or self-funding its health insurance program, and insurance company or possibly even a computer firm will provide the processing services like claims review and claims payment on a, I would assume, a fixed dollar amount.

Q So ASO is essentially self-insurance?

A That's, I guess, in the parlance. ASO normally corresponds with the concept of self-insurance.

Q With insurance companies simply performing administrative but non-insurance services?

A Yes, sir.

MR. GREENFIELD: I'd like to move into evidence, move for admission into evidence, Exhibit 24. The Attorney General has stipulated that this may be moved

into evidence and that he accepts the authenticity and accuracy of the figures. This has made it unnecessary to call special witnesses from Metropolitan.

THE COURT: All right. It may be marked.

(Document, above-referred to, marked Exhibit No. 24)

[3-37] Q Could you explain what Exhibit 24 is, Dr. Larson?

A Is that the document that says Metropolitan Life Insurance Administrative Services Only contracts?

Q Yes.

A What this document is is a compilation of data that was shown to me by Metropolitan Life Insurance Company of the number of new ASO contracts issued over a number of years, and the span of years in this document ranges from 1972 to 1979. Essentially what it presents is an upward trend in the number of new ASO contracts from the year, approximately two contracts to 1979, it shows here, eighteen contracts.

Q Now, based upon Exhibit 24 and the material and research that I previously referred to, have you formed an opinion as to whether there has been an increase or decrease in recent years in the number of employee benefit plans going to self-funded or ASO arrangements?

A Yes, sir.

Q What is that opinion?

MR. MONTGOMERY: Objection.

THE COURT: What's your objection?

MR. MONTGOMERY: Number one, your Honor, [3-38] to the extent that there is a trend, the document speaks for itself. In addition to that, I think that there is no basis, at this point, for believing that this particular witness is an expert with respect to the area of self-insurance of administrative services contracts.

THE COURT: What do you say to that?

MR. GREENFIELD: Let me ask him some questions.

Q In the research that you conducted, both with respect to the Virginia study and subsequent research in

preparing to testify, have you interviewed persons with respect to the trend toward self-insurance?

A Yes, sir.

Q And have you interviewed persons with respect to the trend toward ASO?

A Among the other things that I researched for the study, yes.

Q And at the various legislative hearings that you have attended, has there been testimony concerning the trend toward self-insurance?

A Yes, sir.

Q And based upon those factors which I have just [3-39] mentioned and the earlier factors and Exhibit 28, do you have an opinion—excuse me, Exhibit 24, do you have an opinion as to whether there's been an increase or decrease in recent years in a number of funds going to self-insurance or ASO?

A Yes, sir.

Q What is that opinion?

A There is an increasing trend for employees to turn to self-insurance, ASO contracts.

Q Can you explain how you reached that opinion?

A Well, it was a combination of a number of things. It was a major point that was brought up by employers, and of those employers and insurance companies that I interviewed during the course of my study for the Bureau of Insurance for the State of Virginia. It is a commonly stated fact in particularly the three, as I mentioned yesterday, hearings on the subject that I have personally testified at. It is also based on, again, the data that's exhibited here in Item No. 24 that's submitted by the Metropolitan Life Insurance Company.

Q Now, are you aware of any data of any kind whatsoever, written, oral testimony, interviews, [3-40] anything, are you aware of anything which suggests that there is not a trend towards self-insurance?

A No, sir.

* * * *

CROSS-EXAMINATION
BY MR. MONTGOMERY:

[3-47] Q Would you agree that to the extent that states do mandate particular types of benefits in the insurance policies that it's appropriate that the mandated benefit be properly designed to lead to proper utilization of that particular benefit?

A If the mandated benefit's going to be passed and given whatever the objectives are of such passage of legislation, yes, I think that's very important.

[3-48] Q And would you agree that, for instance, limitations on total recovery are, perhaps, one responsible mechanism that the state could use to limit the impact of the mandated benefit legislation?

A I don't know what you mean by total recovery.

Q That establishing minimums—

A Minimum what?

Q Minimum benefit, for instance, $500, $1,000 a year. For instance, I think you're familiar with Maryland, and I think that their recovery is limited to $1,000 per year per subscriber of the policy.

A Well, I think that pertains to any type of health insurance coverage, not just mandated benefits.

Q So that you would agree that placing that kind of a dollar limit on the recovery when the state mandates a benefit is a responsible thing to do?

A Yes, sir.

Q And how about licensing requirements for providers, would that be an additional limitation on the mandated benefit that would be appropriate in your view?

A That is certainly something that has to be [3-49] considered to assure quality services.

Q Professor, on page 5 of Exhibit 18, you have a chart which lists a series of mandated benefits. One of those benefits which you discuss a couple of times in your report is coverage for new-born care.

A Yes, sir.

Q Do you have an opinion as to why so many states, I believe thirty-seven you mention in your report, have

mandated that group insurance contracts provide for new-born care?

A Yes. There has been a tremendous increase in the cost of new-born care, particularly very sick new-born children, and there has been often cited the instance where a young family would not have adequate insurance to cover those which may be very significant costs for new-born care. That has certainly been one of the arguments made, it's my understanding, at the legislative hearings.

Q Do you believe that the insurance mechanism as it exists in this country, aside from these mandated benefit provisions, has provided new-born care?

A Some insurance companies have; some have not.

[3-50] Q In general, has it been provided? Is it available for most people?

A If they choose to buy it, yes.

* * * *

[3-53] Q Now, assuming for the time being that these, what I think on page 5 you referred to as estimates, reflect actual costs, assuming that for the moment, I'd like to ask you whether you are familiar with the distinction between added costs and shifting costs?

A I'm not sure. I'd need for you to define those for me.

Q So, you're not familiar with those two concepts in economic terms, added costs versus shifting costs?

A Like all terms, they're always roughly used by everyone; it's a little dangerous to assume that.

Q Do you know prior to the mandated benefit, sixteen mandated benefits in Colorado, what the total direct costs in that state were for providing the benefits which are mentioned in those sixteen provisions?

[3-54] A I'm not sure what you mean by direct cost.

Q Well, let me get a little more specific. I'm referring to page 36, which start with chiropractor services.

A Yes.

Q Prior to the time that chiropractor services were covered by the Blue Cross-Blue Shield plan, is it fair to

assume that chiropractors were offering their services to residents of Colorado?

A I would say probably it's fair to assume.

Q And is it fair to make a similar assumption with respect to each of these benefits, that these services were being offered, purchased and paid for in the State of Colorado?

A I don't really know that one way or the other. It might be a safe assumption, but I don't honestly know.

Q Okay. Well, let's assume that to be true for the moment. Assuming that to be true, I will ask you whether you know or have you any data with respect to the total expenditures by the residents of the State of Colorado for all of the services which underly these sixteen mandated benefits—prior?

A I don't know of, no.

[3-55] Q Now, would you agree that the—Professor, did you draw a conclusion as to the total cost in Colorado of these benefits? I'm not sure I see that.

A I'm not sure what you mean.

Q Did you perform a projection in Colorado similar to Exhibit 22?

A In other words, premium expense times the number of enrolled persons?

Q In Colorado.

A No, sir.

Q Okay. Would you agree that had you had done such a calculation that it would only represent the additional—it would only represent premium costs for those services?

A Yes, sir.

Q And that to some extent that premium cost would represent a shift in the nature of payment for those services?

A What do you mean by that?

Q Well, previously the services were provided, and now they're being provided but paid for by a different source.

A I'm sure there's some shift; I don't know the exact [3-56] magnitude.

Q You can't distinguish, with respect to Colorado data, the shift in cost from additional costs?

A No, I don't know that, no.

Q But would you accept that there's going to be some shift and some addition?

A Not entirely. I'm having a problem with your question and let me just tell you why. Because, very often these types of services are provided under other forms of insurance, so I just don't know what the array of benefits of this Blue Cross organization, you know, in detail offered. That's why I'm having a problem with the question.

Q That's an interesting comment. Do you know the extent to which these benefits were provided by other forms of insurance prior to the state mandate for group insurance contracts?

A Well, I'll give you an example. You see, very often these mandated benefits may simply mean to pay the practitioner on an independent basis. But very often, under maybe a hospital coverage the insurance company was paying for it because the practitioner was part of some sort of health service or hospital service, and the only difference [3-57] is they've moved from the domain to be independent practitioners. You know, the magnitude of the shift, there's so much unknown there that I don't know.

Q Okay. So that when you talk about additional premium cost, you're only talking about additional premium costs for group insurance policies?

A No. But it could cost more money because the practitioner is practicing independently as opposed to a provider group formally, so it may be a shift and an addition.

Q Okay. But with the example you just gave me, prior to the statute, he was being paid through the insurance mechanism; subsequent to the statute, he was

being paid through the insurance mechanism; isn't that right?

A But he may be paid more.

Q Okay.

* * * *

[3-63] Q Professor, I'm referring to page 12 of Professor Samuelson's text on economics, in which the fallacy of composition is defined as, "a fallacy in which what is true of a part is, on that account alone, allegedly to be also necessarily true of the whole. Very definitely, in the field of economics it turns out that what seems to be true for individuals, is not always true for the society as a whole." Referring now to page 566, another reference to the fallacy of composition, and quoting from the fourth paragraph: "What is true for a small sector of the economy need not be true for the whole aggregate." Do you recall now having heard this definition of the fallacy of composition, what it is?

[3-64] A Generally, sure. It's been a long time since I've seen it.

Q Do you think that the fallacy of composition has any relevance to the cost projections that you've made in Exhibits 22 and 23?

A I'm so unfamiliar with the concept and read the book, I wouldn't want to hazard a guess.

Q Well, you think that it's important in making a projections of the type that you have to examine the underlying market for the services which are the subject of the projection?

MR. GREENFIELD: I object as to form. I don't know what that means.

THE COURT: I honestly don't either. Can you rephrase that; I didn't understand it myself.

Q I'll try again. In making the projections that you —the type of projections that you made in Exhibits 22 and 23, do you think that it is important to examine the demand for the services represented by the projections?

A To have a more accurate projection, sure.

Q And have you performed any analysis of the demand, nationwide demand, for the services that [3-65] you project will yield an additional premium of $5 billion?

A No, sir, the data's not available.

Q Okay. So, you don't know whether, in fact, there is a sufficient consumer demand for those services that $5 billion in additional premium would be required?

A No, sir.

Q Now, and, of course, just to state it another way, would you agree that your projection is based upon an assumption—

A Yes, sir.

Q —of sufficient demand?

A Yes, sir.

Q Is your projection also based on an assumption that there is sufficient supply of providers of those services?

MR. GREENFIELD: Your Honor, I'd like to object. We're dealing with mandated statutes which say irrespective of demand, irrespective of supply, you have to offer it. The witness's testimony and his opinion are based on mandated statutes. It has nothing to do with the particular demand or supply because the statute has nothing to [3-66] do with demand or supply.

MR. MONTGOMERY: I'm not asking about the statute.

THE COURT: It's overruled.

Q Professor Larson, in your experience does the premium cost that insurance companies assess for providing a particular benefit have any relation to the demand for the service?

A In my experience—the reason I'm pausing on that is because to give an accurate answer there—obviously, the premium expense has to be some reflection of the use of a service, absolutely, but it's not the total reflection, by no means.

Q Well, what else does it reflect?

A Well, the premium includes things like the profits for the commercial insurers, reserves, administrative ex-

penses; so the premium is not totally just claims experience.

Q Well, Professor, again referring to page 36 in your chiropractor services, and to get very simple, if there were no chiropractors in the State of Colorado—

A Yes.

Q —do you think Blue Cross-Blue Shield would charge [3-67] the same premium?

A That's very difficult—you know, it's a cause and effect. It depends on—

Q Thank you.

MR. GREENFIELD: Let him finish.

Q Would you like to make an additional comment on that?

THE COURT: He probably wants to chat about it. You can continue.

MR. MONTGOMERY: Excuse me for interrupting.

THE COURT: You can continue.

A What I'm trying to say is that very often, by the existence of insurance, often brings about the supply and, so, whether the supply existed before the law was passed or simply the insurance company chose to offer the coverage, often, you know, the demand does not necessarily exist before the coverage provided. Am I clear on that?

Q Yes, I understand. Now, are you familiar with the Colorado statute which mandates a minimum mental health benefits?

A No, sir.

Q You do know, I would assume from page 36, though, [3-68] how much Blue Cross-Blue Shield has projected it would cost to provide that service?

A In terms of projected claims experience?

Q Yes.

A No, I don't.

Q Excuse me, not claims but premium requirements. I think on page 36 you have $1.60 per individual and $3.52—

A That's purely premium expense.

Q Now, do you have a similar cost projection for the State of Maryland?

A Well, I suppose there would be where the benefit was similar, but I don't know which benefits are similar or identical.

Q Well, I'm referring to the mental health, mental or nervous conditions benefit.

A Yes, sir, but I don't know whether the structure of the benefit is the same from state to state.

Q Okay. So that in making your Colorado projection, you assume that each of the mandated benefits would be identical across the country; is that it?

A It would have to be, yes, sir.

Q Now, referring to page 98 of Exhibit 18, isn't it [3-69] correct that Colorado projects a cost of $.70?

MR. GREENFIELD: You mean Maryland?

MR. MONTGOMERY: Maryland, yes.

Q It's $.70 for the mental or nervous condition?

A Yes, sir, that's what's on page 98.

Q Do you have any knowledge of why Maryland was going to charge $7.70 and Colorado $1.60?

A Specifically, no.

Q Are you familiar with the Maryland statute?

A I've read it, but my recall would be next to nil, probably.

Q If we assume that the Colorado statute places no dollar limit on the extent of recovery per person and we further assume that the Maryland statute places a limit of $1,000 per year, would you be able to form an opinion as to whether those two distinguishing factors would have an impact on the difference in the project premium cost?

A Are you saying the benefits are the same in each of the two states?

Q Well, the benefits are the same except to the extent that one is provided, has no limit on the amount that an individual can recover, and the other in Maryland has a $1,000 per year limit. [3-70] The question is: Would that have an impact?

• • • •

[3-72] Q In general, do you believe or from your experience do you have an opinion as to whether the limitations that are placed upon dollar recoveries on a mandated benefit statute have a significant impact on the premium cost?

A Any time you put a dollar limitation, you have to provide some—that has to limit the amount of claims that can be brought against your policy.

Q Okay. Do you have any personal knowledge as to the limitations that have been placed by the Maryland legislature on its mandated minimum mental health benefits statute?

A Nothing I recall, no. It may or may not be, I just don't recall.

Q Now, on your direct examination you mentioned the experience of the federal employees and their insurance benefit program?

A Of the testimony, yes, sir.

Q Are you directly familiar with any of the studies that have been done with respect to the experience [3-73] of federal employees?

A I have seen some, yes.

Q Are you aware that some time ago Congress mandated a provision for minimum mental health benefits for federal employees?

A I just—I'm sure that's true. I just don't know. I don't recall that.

Q Are you aware that there is an optional provision in the federal employee plan which allows each federal employee, qualifying federal employee, to purchase a mental health benefit?

A I just don't know that as a fact. I'm sure it's true, I just don't know that myself.

* * * *

[3-87] TESTIMONY OF THOMAS J. HEFELE]

DIRECT EXAMINATION
BY MR. MONTGOMERY:

Q State your name, please.

A Thomas J. Hefele.

Q Where do you live, Doctor?

A 47 Fairway Drive, Groton, Massachusetts.

Q And where are you employed?

A Psychological Associates of Groton—27 Boston Road in Groton .

Q Thank you. What is your position with Psychological Associates of Groton?

A I'm the director.

Q What is that entity?

A It's a private group practice consisting of non-professionals, five psychologists, three psychiatric social workers, and one psychiatrist.

Q Now, in addition to your position with Psychological Associates of Groton do you hold any other current employment position?

A No other paid employment, but I do have a number of affiliations which bear directly on my practice.

Q Would you please state those affiliations?

[3-88] A I hold an appointment as an Assistant Clinical Professor of Psychiatry at the Boston University School of Medicine. I'm a member of the Medical Dental Staff at Burbank Hospital, a general hospital in Fitchburg, Massachusetts. I hold a courtesy staff appointment at McLean Hospital in Belmont. Those are the affiliations which most directly relate to my actual employment.

Q Would you briefly describe your educational background?

A I have a Ph.D. in Psychology, studies completed in 1969 at the State University of New York at Buffalo, as well as significant post-doctoral studies.

Q And are you a member of any professional associations?

A I'm a member of the American Psychological Association and various divisions of that association. I'm also a fellow of the Massachusetts Psychological Association. There are a number of other professional memberships, but I don't want to bore the Court with a long litany.

Q Do you hold any positions of responsibility in connection with any of the professional associations?

[3-89] A I am currently treasurer of the Massachusetts Psychological Association. I'm also a member of the seven-person committee on professional practice of the American Psychological Association.

Q And have you held any past positions of responsibility in connection with any of your professional associations?

A I have been a member of the Board of Directors of the Massachusetts Psychological Association for several years prior to election as treasurer. I also was chair of the Insurance Committee for the Massachusetts Psychological Association. I would like to backtrack, if I may. There was one item which I neglected to mention in connection with professional employment and affiliation.

Q Yes.

A I am also a paid psychology consultant with Blue Shield of Massachusetts.

Q In connection with your duties as a paid consultant with Blue Cross-Blue Shield, if I might just ask you—strike that question. What are the nature of your duties that you perform as a consultant to Blue Cross-Blue Shield?

A I assist in the development and implementation of [3-90] their utilization review system. Also, I consult with management on various problems and policies in the implementation of the mental health benefits.

Q In connection with your utilization review responsibilities, are those confined to the mental health area?

A Yes.

Q Now, have you published any articles in any professional journals and publications?

A Yes, I have.

Q Would you please, if you can recall, recite some of those publications?

A Well, several of the journals would be: Psychonomic Science and the Journal of Clinical Psychology and the Counseling Psychologist. There have been a variety of presentations at conventions and meetings as well.

Q Could you please briefly describe your practice, your group practice in Groton, please?

A We are a multi-specialty group practice which provides the full gamut of psychological services to persons ranging from very young children to the elderly, treating disorders ranging from mild transient situational disturbance to major [3-91] psychoses.

Q Are you familiar in your professional experience with the various types of conditions which are subject to —mental and nervous conditions which are subject treatment by professional providers?

A Yes, we have dealt with all of them.

Q Would you please categorize or at least list the types of problems that a professional such as yourself would deal with?

A That gets to be a very difficult question to answer briefly. Suffice to say that we deal primarily with persons with neurotic disturbance, a variety of character disorders, situational disturbances and psychoses, as well.

Q Now, in connection with treatment of these various types of problems are there a variety of delivery mechanisms for treatment of mental and nervous conditions?

A Well, there are basically two or three delivery mechanisms.

Q What are they?

A The one with which I am most directly involved and most extensively would be the out-patient [3-92] treatment model. The second one would be the in-patient treatment model, with which I am also involved. And then a third one would be a kind of like, I guess, a partial

hospitalization or halfway house type model, and that I am not involved with.

Q Now, how long have you been involved in your group practice in Groton?

A The group practice itself has been in existence for three years.

Q And how long have you been in practice in Groton outside of the group practice?

A I have been in practice in Groton since late 1974.

Q Now, are you familiar with Section 47b of Chapter 175?

A Yes, I am.

Q If you could, Dr. Hefele, I'd like you to—strike that. Let me ask you, since approximately 1976 has there been any change in the types of problems that you've treated in your group practice?

A Yes. In my own—

MR. GREENFIELD: Your Honor, the witness testified he's been in group practice since '77.

MR. MONTGOMERY: I would strike that [3-93] question. Let me ask the question again.

Q Since 1976, has there been any change in the types of problems that you have treated in the course of your professional experience?

A I have dealt increasingly with persons with significant physical illness.

Q Could you elaborate on your answer and give some examples of what you mean by clients with physical illness?

A I deal with a significant number of people with high blood pressure, tension and vascular headache, chronic pain, significant brain damage, or other forms of neuropsychological impairment, persons with the various concomitance of anxiety neurosis, namely gastro-intestinal symptomatology, nervous tensions—

THE COURT: I didn't get that last part of your answer.

THE WITNESS: The gastro-intestinal symptomatology.

Q Now, what is the difference—I don't think we need to go into any great detail on the nature of those problems—but what is the difference between the range of problems that you described [3-94] as the dominant portion of your practice since '76 and the type of practice you had prior to then?

A Typically, before that it was more a matter of dealing with more traditional neurotic disturbance, depression, adjustment problems.

Q Now, prior to 1976, can you please just explain the source of your client—how did you come by your clients?

A The typical network of referral, you know, somebody knows somebody—

Q Would you explain the types of referrals that resulted in your treatment of clients?

A I really want to kind of hedge on that question; I'm foggy on that. I'd really have to spend a few minutes thinking back, and I'm not sure if I could give you a very accurate answer.

Q Well, let me ask you, has there been a change which you can identify in the source of your clients since 1976?

A I have been increasingly—and this is looking very clearly at the past few years which are the ones, obviously, which are the closest to me—I have seen a very marked increase in [3-95] referrals from physicians.

Q Can you estimate the percentage of your clients who are referred by physicians?

A Within the—I will respond personally, rather than to the whole group practice. Personally, approximately 80 percent of the patients that I see come from physicians.

Q Does that represent any change, any trend?

A That represents a marked change in trends.

Q Can you identify the onset of that change?

A I really can't anchor it at a specific point in time; it has happened gradually over the past three, four years. Certainly, it has happened since the inception of the mental health insurance law. I know one factor there was

that many physicians felt more comfortable referring because they knew then that their patients would be able to deal with the costs of treatment.

Q Now, in addition to physician referrals are there any other referral sources in the course—that you have experienced in the course of your practice?

A I think, if you could name the referral source, we've probably gotten referrals from that source.

Q Let me ask you—

[3-96] A Among those would be hospitals, courts, schools, welfare department, probation officers, local Army base.

Q Let me ask you about referrals, you mentioned a number of referrals from government agencies, from government entitities.

A Yes.

Q Do you know what portion, if you can estimate, what portion of referrals come from government?

A Are you including school systems?

Q Yes.

A 15 to 20 percent. That is—I'm sorry, focusing on the whole practice, it's more substantial.

Q Does that represent any change from your experience, your referral experience, prior to 1976?

A Yes.

Q Do you know the percentage of referrals to the entire group that come from government entities including schools and courts and the welfare department?

A I would like to give you a number that I could have confidence in. I can't give you a really accurate number. I would estimate perhaps 40 to 50 percent, but that is a very rough estimate.

[3-97] Q Can you give a rough estimate of the percentage of such referrals prior to 1976, to you personally?

MR. MC GOVERN: Well, could he lay a basis for this first? I mean, has he seen any records, or this just out of the blue that he's coming up with this? There ought to be a foundation laid before he can make any statements like that.

THE COURT: Was that an objection?

MR. MC GOVERN: It is an objection, yes.

THE COURT: You may have your answer.

MR. MONTGOMERY: I think the question that I had asked: Do you know the approximate percentage of referrals in the course of your own practice prior to 1976, that came from government entities, including the courts, the state welfare department, and the schools?

MR. MC GOVERN: Well, I'm sorry. I thought he was going beyond his own practice.

THE COURT: That wasn't the question I remember either. I thought that the question you asked was framed to elicit an answer as to [3-98] the group practice, prior to '76. That's what I thought you had asked.

MR. MONTGOMERY: If I gave that impression, I apologize, your Honor, because the group practice didn't exist prior to '76, and I really meant to direct it at his personal experience prior to 1976.

THE COURT: Okay. No problem.

A What am I supposed to answer?

Q The approximate percentage of referrals prior to 1976 in your personal practice, that came from public entities.

A I would be hard put to give you a figure at this point. I really have not thought about that.

Q May I ask you if there had been a change since 1976 in that percentage, which I think you said your personal practice was 15 or 20 percent?

A With the marked shift, in that prior to—I go back to 1974-'75, I did substantial contract work for the State Department of Mental Health and the Department of Education. At that level, virtually all, or very close to all of the referrals at that point were through those public agencies, being paid for through contract funds. Subsequent to [3-99] that, when that dropped off people were then coming utilizing health insurance benefits. Subsequently, there was an increase in referral from various governmental entities, encouraging people to secure treat-

ment utilizing the third-party insurance coverage. And so it's sort of been a swing.

Q Perhaps then I could ask a final question: Has there been a shift in the source of payment for the services you provided to clients since 1976?

A Oh, clearly, clearly and unquestionably.

Q And, could you please explain that change in source of payment?

A I would say 60 to 80 percent of the practice income is from third-party coverage.

Q And prior to 1976, and in your personal experience then, what percentage—

A Perhaps 10 percent was from third-party coverage, if even that much.

Q In the course of treating your clients, is it your regular practice to examine, or did you become familiar with, for instance, their employment and income history?

A Absolutely.

[3-100] Q Would it be fair to say that you've become familiar, in general terms, with the socio-economic class of the clientele that you treat?

A If I didn't, I would be getting a poor history.

Q And since 1976, have you observed any change in the socio-economic class of the patients that your clients—

A I am seeing now, many more working class and lower class people than had been the case in the past. I'm finding them walking into the office with much less trepidation about seeing a shrink, and what that might mean.

Q And with respect to those working class clients that you do treat, what generally is the source of payment for those clients?

A Third-party coverage.

Q When you say "third-party coverage," do you mean insurance companies?

A Yes.

Q Now, in the course of your professional experience, Dr. Hefele, did you have occasion to observe or draw conclusions for each of your clients with respect to the

benefits that they derive from the treatment that you've rendered?

[3-101] A Most certainly.

Q Are there various types of benefits that in your professional opinion your clients have derived from their treatment?

A There are personal benefits in terms of diminishing or elimination of the presenting symptoms. There are benefits to their families. There are benefits to their employers. I think there are benefits to society beyond that.

Q Well, let's take that one at a time. With respect to personal benefits, could you elaborate a little bit more on what you mean by—perhaps you could give an example from your experience of someone who has benefitted personally and explain specifically what you mean.

MR. GREENFIELD: Your Honor, I'd like to object on the grounds of relevance. We are not attacking mental health treatment. We are not claiming that mental health treatment is not to peoples' advantage. Our claims, under ERISA, the N.L.R.A. and under the Constitution, and are not based on the fact that there's something wrong with mental health treatment. We concede that in many cases, it does people good. Our [3-102] claim is under, among other things, under ERISA and the N.L.R.A., is that, at least with respect to what should be mandated and what should not be mandated, Congress has said that those choices should be up to employers and employees. But we concede, at least Metropolitan concedes, that mental health treatment helps a lot of people.

THE COURT: I appreciate your argument. Unfortunately, it's overruled. You may have your questions and answers in this line, by the way.

MR. MONTGOMERY: Thank you. I would be glad to respond if the Court cares to hear.

Q I think the question that was before you, Dr. Hefele, will you please give examples, or give me an example from your personal professional experience, of

the type of benefit that has accrued to a client as a result of the treatment which you gave.

A If an individual comes to me complaining of severe and unremitting pain in the lower back which makes it impossible for him to remain out of bed for more than three or four hours a day [3-103] and after treatment, he is able to get up, move around, go to work and earn money to support himself and his family, then I think it's a rather significant benefit.

Q Have you treated such clients?

A Yes, many times. If he then also manages to have the chronic depression with which he has suffered alleviated, as a function of relief from the pain, then that's a significant benefit.

Q Sir, is there a relationship between pain and depression?

A Yes. It's precisely corrolated—highly corrolated. That's between chronic pain and depression. Acute pain and anxiety bear a strong relationship. Chronic pain and depression are highly related.

Q Are there any other examples that come readily to mind from your personal treatment experience of the kinds of benefit that accrue an individual—

A Well, if an individual has a history of three unsuccessful suicide attempts and continual complaining about suffering deeply with many internal conflicts, and they leave treatment no longer talking about killing themselves, but rather about facing new challenges and feeling good [3-104] about themselves, and going out and being productive, I think that's also a significant benefit.

Q Now, that's a very general description. Have you treated specific persons, residents of the Commonwealth, who have exhibited this?

A Yes.

Q Now, you've also mentioned, in addition to personal benefits, you mentioned more generalized benefits to families. Would you please elaborate a little bit more on what you mean by that?

A To the extent that a family has a very emotionally disturbed member, it has a very significant effect on the mental health and discomfort of the remaining members of the family. To the extent that that person gets better, particularly if it's a parent—father or mother—father, particularly, if the father is the primary wage-earner who is not employed gainfully during the period of the difficulty, there is then clearly a very significant benefit.

Q Now in the course of your practice, have you had an opportunity specifically, to observe on the impact of treatment on an entire family?

[3-105] A Yes.

Q And how would you have that kind of knowledge when you're treating when you're treating one member?

A We do a good deal of family therapy in the context of our group practice. One of the folks who works for me is a highly expert family therapist. We see individuals, couples and whole families quite frequently.

Q Now, in addition to the personal benefits and more generalized family benefits, you also mentioned benefits to the society, a couple of which I think you've mentioned in the course of your examples. Do you have any other—would you elaborate on what you call a social benefit?

A One benefit to society, which I have seen occur repeatedly, is a person who is dependent upon public assistance for support, in view of their emotional disabiilty, finding that it's possible to remove themselves from public assistance and secure gainful employment, contributing thereby to the public through payment of taxes, rather than through removal of revenues from society.

Q And is it possible for you to estimate the number [3-106] of people who you have treated who have, because of their ailment, been on public assistance?

A I would be hard put to do that with accuracy. Suffice to say that there have been a significant number.

Q Now, Doctor, in connection with a couple of your examples, you mentioned both physical conditions and

mental conditions, in the course of the same examples. Is there any relationship between the two?

A Unquestionably, they're quite interdependent.

Q And have you had an opportunity, in the course of your professional experience, to study that interrelationship?

A I've had the opportunity to study that, both theoretically, through formal post-doctoral studies in the field of Behavioral Medicine, and also, to study experimentally, through rather extended practice with the diversity of people with physical and emotional ailments, where I've seen both operate concurrently.

Q Are there any other examples, other than those that you've given, that might further enlighten the Court on the relationship between physical [3-107] illness and mental conditions?

A I could give you an academic lecture that would last three or four hours. I'm not sure you want that.

Q No, I'm asking for a specific example, and you've given a couple already. I just really want to know if there are anymore than would further explain this relationship.

A Well, I can tell you a story of an attorney, if that would help. This was a thirty-two year old female attorney, referred to me by her gastroenterologist for severe colitis condition. In the course of treatment, it became apparent that very significant determinants for the colitis were a rather pressured existence—a type A behavior, to use some of the professional jargon, which were contributing to the lack of opportunity for omission of the ailment. Likewise, there were also some rather significant childhood conflicts which hadn't been resolved, which were putting her into some significant double-bind situations which were creating significant internal pressure. In the course of psychological treatment, both behavioral and insight oriented, there was virtually [3-108] total remission of the gastrointestinal symptomatology and elimination of use of medication.

THE COURT: You're excluding the attorneys that are present here, the lady attorneys; you're not referring to any of them, are you?

THE WITNESS: No.

Q Doctor, you testified that approximately 80 percent of—

A I could tell you the story of an Assistant Attorney General who was very depressed—he has since moved out of state and into private practice.

Q You testified that approximately 80 percent of your practice, or your client population, results from physician referrals.

A Yes.

Q Where you receive a referral from a physician, do you, as a matter of your regular practice, examine both the physical and the psychological and mental history of that patient?

A Yes, quite thoroughly.

Q And to what extent do you examine the prior physical history and treatment of that patient?

[3-109] A I get a full copy of the previous medical record and review that in detail, and where appropriate discuss that history with the referring physician.

Q Now, have you observed in recent, the last two or three years, any change in the nature of the previous physical treatment of patients who have been referred to you by physicians?

A There is less of it, meaning that the referrals are coming sooner.

* * * *

[3-127] REDIRECT EXAMINATION
BY MR. MONTGOMERY:

Q Dr. Hefele, in your opinion do we have an optimum program across the United States for the treatment of mental and nervous conditions?

A No way.

Q In your opinion, are statutes which mandate coverage in group insurance contracts for the [3-128] treat-

ment of mental and nervous conditions an important component of the current treatment approach?

A I believe those statutes are a highly significant step forward. I also believe that in many ways the statutes need to be more elaborate, more extensive.

[3-129]

[TESTIMONY OF GERALD BOROFSKY]

DIRECT EXAMINATION
BY MR. MONTGOMERY:

Q Would you state your name, please?

A Gerald Borofsky.

Q Where do you work?

A I work in a variety of settings. I'm the Director of Psychology at the Eric Lindeman Mental Health Center, which is a mental health, community mental health center operated by the Department of Mental Health. I'm the Director of Psychology in the Department of Psychiatry at Massachusetts General Hospital, and I am a member of a private practice group of psychologists, called Bay State Psychological Associates.

* * * *

[3-133] Q Now, in the course of your experience, Doctor, have you had any occasion to study the different types of costs of mental illness nationally?

A In a very general way, yes.

Q And could you describe the nature of the study that you've made of the costs of mental illness?

A Well, I've been aware of data from the National Institute of Mental Health which shows that there are basically two types of costs for mental illness. There are direct costs, direct patient treatment costs, and then there are indirect costs, such as housing for mentally ill—

MR. GREENFIELD: Objection. Hearsay.

THE COURT: Overruled.

[3-134] A The data also include indirect costs for mental health, such as I say, housing for the mentally ill, plus such things as disability and death-related costs

that result from mental illness. And, I might add that the indirect costs are somewhat substantially greater than the direct treatment costs, the cost to society as a whole.

Q Doctor, are you familiar with the various mechanisms for the delivery of services for the treatment of mental and nervous conditions?

A Yes, sir. There are basically three types of mechanisms, three classes of mechanisms: the in-patient mechanism of treatment, what would be called a transitional or after-care mechanism of treatment, and an out-patient mechanism.

Q Now, in your experience in recent years, have you observed any change in the mix of out-patient and the in-patient treatment in the Commonwealth?

A Yes, I have.

Q And what's the basis for your conclusion that there's been a change?

A Well, as you noted from the kinds of work I do, I have a kind of interesting vantage point on the situation, which is that I work in the public [3-135] sector in the private hospital sector, as well as in my own private practice. And in all three sources of personal experience, as such, I've seen a marked decrease in the use of long-term hospitalization. There's been increasing evidence that hospitalization should be avoided any time it's possible largely because of the enormous cost involved financially, and because of the enormous human cost in terms of family disruption that occur when a person has to be hospitalized. So that there's been a trend away from hospitalization if at all possible, and where necessary, absolutely necessary, there's been a tendency to make those hospitalizations as short as possible. So the thrust has been to shift wherever possible to focus the treatment to the out-patient sector.

Q Okay. Has there been any change in the focus of treatment or the mix of treatment as between public facilities and private facilities, in your experience?

A Yes, there has. There's been a trend toward trying to increase the number of providers in the private

sector, the number of professionals qualified [3-136] to provide those services. And as a result of that there has definitely been a shift toward the private sector and away from the public sector for out-patient services.

Q And that shift from public to private sector treatment, has that had an impact, for instance on the Mass. General Hospital clinic?

A Yes, in fact it has. It's enabled the Department of Psychiatry to develop a very comprehensive range of psychiatric and psychological services and to pay much more attention to many more of the subtle kinds of disorders that were previously misdiagnosed or undiagnosed, so that we are able to have developed a very first-rate range of services as a result of this.

Q Now, how long have you been with the Mass. General Hospital again?

A Since 1972 is when I joined the staff, although as Director of Psychology it's been since 1976.

Q And can you identify the beginning or the onset of the development of this trend that you identified, the change from public to private treatment for these kinds of conditions?

A Yes. It's very definitely been within the last [3-137] three years, three to three and a half years because it coincides with the advent of our new Chief of Psychiatry quite closely.

Q Now, you just mentioned, I think, a couple of moments ago a policy favoring the increasing—the development of increasing the number of providers for mental health services?

A That's correct.

Q Have you actually observed a change in the Commonwealth of Massachusetts with respect to the number of providers?

A In the Commonwealth itself—

MR. MC GOVERN: I think I will object. He has experience in three specific localities. We're now talking about numbers of providers. I don't think a basis has

been laid for him to know what's going on all over Massachusetts with respect to specific numbers.

THE COURT: He may answer that he doesn't know, but until I find an answer I won't be able to—you may answer.

A Yes, there has been an increase in the number of providers as evidenced by the increased numbers of psychologists who are being licensed for [3-138] independent practice by the Board of Registration of Psychology in the Commonwealth.

Q And you're specifically familiar with the licensing practice in the Commonwealth.

A Yes, I am.

Q Are you aware of the extent of the increases in the number of providers of psychological services in the Commonwealth?

A Very definitely from a number of sources.

Q And could you identify the sources?

A Two of the major ones that, perhaps, I can share. One is in our own private group practice; the striking increase in the number of requests for employment by providers of psychological services that come to us each week in the form of resumes. I'm also familiar with the rapid expansion of group practices and private clinics throughout previously unserved and underserved areas of the Commonwealth.

Q And could you identify the particular group practices and the areas in which they operate?

A Certainly. Earlier, you heard of one in the area, a previously essentially unserved area, which involved the Groton-Pepperell-Littleton-Townsend [3-139] area. And there's a similar one—there are several clinics, in fact, in Newburyport, Amesbury, Georgetown and the Rowley area, the Danvers-Peabody area. It was also been an influx of several group practices in the Burlington-Woburn area, in the Worcester-Marlboro area, just to mention a few.

Q Now, do you know whether any of those particular group practices operated in the Commonwealth prior to 1976?

A Yes, I do know that. The answer is no. Excuse me, I was looking over at my colleague—Dr. Hefele's date was 1974?

Q I believe he testified his group practice was in 1976. Now, in the course of your experience have you observed since 1976 any change in the distribution of mental health services among various segments of society or socio-economic classes in society?

A Yes, in fact, that's been one of the most striking changes in recent years.

Q And could you please identify from your personal experience the nature of that change?

A There's been a striking increase in the utilization of out-patient mental health services [3-140] by working class and lower middle class individuals in the Commonwealth.

[3-142] Q Now, on the basis of your professional experience have you become familiar with any impact that treatment for mental and nervous conditions has on an employment-related problem?

A Very definitely. In the profession, the mental health profession, it's accepted wisdom that symptoms such as, or signs such as decreased productivity, increased absenteeism, increased industrial accidents, increased grievance procedures, increased employee turnover and the [3-143] like can often be symptoms of mental illness in the employees where these problems are occurring. I've seen in my own private practice and I've seen it in the cases I've supervised at the hospital as well, in the mental health center, is that psychological interventions with such individuals have an impact not only on changing these problems in the job area but also have an impact in terms of the families of these individuals, who are very often very troubled people. Actually, there's one other point as well, which is that we've also observed—and I've observed in these settings—individuals

who previously were kept in state hospitals and considered essentially incurable, with appropriate out-patient treatment and support services have been able to become independent citizens who've been able to hold jobs and contribute meaningfully to the Commonwealth.

[4-3]

[TESTIMONY OF THOMAS G. McGUIRE]

DIRECT EXAMINATION
BY MR. MONTGOMERY:

Q State your name, please.

A Thomas G. McGuire.

Q Where do you live?

A 86 Greenlawn Avenue, Newton Center, Massachusetts.

Q And where are you presently employed?

A Presently I'm a post-doctoral fellow in mental health evaluation at Yale University. This is a temporary position. I'm also on leave from the Department of Economics at Boston University.

Q And what is your position at the Department of [4-4] Economics at Boston University?

A I'm an assistant professor of economics.

* * * *

[4-7] Q Are you familiar, Dr. McGuire, with the subject of mandated state benefits for the treatment of mental and nervous conditions?

A Yes.

Q And has any of your work—does any of your work [4-8] bear directly on the subject of mandated state benefits for the treatment of mental conditions?

A Yes. I highlight two things. The work that I'm beginning this year, which I haven't done, from which I can't draw any conclusions, is on the effect of various state regulations, including direct recognition laws, including minimum mental health benefits, including licensing laws on the delivery of mental health services. Work that I have completed is in a book that I have written that is going to be published this fall by Ballinger Press,

called "National Health Insurance and Psychotherapy: Issues and Evidence," and that book is a study of the federal counterpart of that state regulation, and that federal counterpart is compulsory insurance from the federal level of national health insurance. But I would say that many of the same principles apply at the federal and state level.

Q Now, in analyzing the subject of mandated benefits for the treatment of mental and nervous conditions, could describe the general approach that you take?

A Well, what needs to be done in the beginning is to consider what the issues are, and in doing that [4-9] it's necessary to take a look at what the practices are in the different states and what the policy proposals are both at the state and the national level. To go from there to the study of the actual workings of the various sectors that are involved, and by that I mean the insurance industry which provides coverage for these services and the delivery systems themselves—what are these insurance services covering? Having come to some understanding of them, then I applied economic analysis to try and understand where these things work well, where these things do not work well, and use that to identify any questions that have not been adequately addressed by the existing literature, which would be both theoretical and empirical. Then I proceeded from there to do some of my own research and to try and fill what I thought were the important gaps, putting my research together with what is already in the literature and then to try to draw some conclusions from policy.

Q Specifically, have you studied the functioning of the market for mental health services and in addition to that the nature in which the insurance [4-10] mechanism in the United States has delivered those services—reimbursement for those services?

A Yes.

Q And could you describe a little bit more specifically the process that you follow in analyzing the market for delivery of those services?

A Well, I would say that the process goes under a code name in economics of market failure, and what that means is that if you are looking at a market, either the market for insurance for these services or the market for psychotherapy, you use economic theory to try and shed light on what might be the problems in this kind of market. Then, with this as a guide, with economic theory as a guide, try to find out something about the seriousness of those problems through empirical research.

Q And as a result of the analysis that you have made of insurance markets and the market for psychotherapy have you been able to draw any conclusions as to the nature of the, as I think you call, economic deficiencies in the market?

A Yes.

Q And could you please identify the deficiencies [4-11] that you are referring to?

A Well, the major deficiency I found in the market for insurance for mental health services has to to with adverse selection. In the market for the delivery of services itself, the major deficiency is that many of the benefits of receiving mental health services appear not to go directly to the user of the services but go to society, which private markets then may not respond correctly to that problem. And a third deficiency, I'm not sure quite where to put it, but it has to do with the fact that voluntary markets are not very good in incorporating society's wider interests, compassionate interests, in the treatment of individuals.

Q Okay, now, starting first with the concept of adverse selection and its impact on the market, could you please define what you mean by that term, adverse selection?

A Okay. Adverse selection results from the way insurance companies must price their services, which is insurance coverage to individuals and groups. It's a fact of life in the insurance industry that premiums must be set according to [4-12] the average behavior of groups, for example, the residents of New York State, the em-

ployees of a certain firm, even within the employees of a certain firm it might be the employees twenty to thirty years old, but, nevertheless, a group must be identified and the premiums set according to the expected average behavior of that group. Now, within the group that the insurance company uses to set its rates, only a very few people will be exactly average; none might be exactly average in fact. Many people will be on the one side of the average and the others will be on the other. Some people actually present more risk to the insurance company than the average; some will present less. Now, if insurance is provided in a voluntary manner by a market in which people may or may not choose to buy the insurance, then once a premium is set true for a group, the people who present more risk to the insurance company, in fact, than the average will find the insurance an especially good deal. For them the premium is too low in some sense. It does not accurately reflect the risk the insurance company must bear when it takes their policy. But the [4-13] people on the other side of the average, the premium will be too high in that the risk they really present the insurance company is much lower than that referring to the average premium. So if people can choose or not to take that insurance, the people who are worse on the average risks will be the people who choose it, and the people who are less than average in terms of risk may not choose it. And that's where adverse selection gets its name. The insurance company, because it has to rely on the voluntary decision of people to take or not take their policy, draws an adverse selection of the population they try to insure.

Q Now, in an insurance market, or in a market involving an insurance benefit, which may be subject to serious adverse selection, how do consumers in the market express their preferences or their choices with respect to whether they want a particular benefit?

A Well, it's really very simple. They choose a policy or not choose a policy. If there is more than one option available on the market, they would choose the one which,

according to their [4-14] one perception of their risk and judging that in relation to the premium cost they would choose to buy it or choose not to buy it.

Q Have you been able to identify any implications with this very general notion of adverse selection as for policy concerning mandated benefits for treatment of mental conditions?

A Yes.

THE COURT: Could you repeat the first part of that question? I didn't follow you.

MR. MONTGOMERY: I will try to repeat the question.

I think the question was, have you been able, in the course of your experience, to identify any implications which this concept of adverse selection, theory of adverse selection has for government policy towards mandated benefits for treatment of mental and nervous conditions?

A Yes. I think in order to answer that, if I may, it would be helpful for me to first describe the implications of this for the workings of the insurance market and then describe how policy [4-15] should react to the market.

So, what are the implications of adverse selection for the workings of insurance markets?

Well, I have described how rates need to be set by insurance companies and how individuals may respond to those rates. Well, you can imagine the insurance company coming into a group or a firm, setting rates appropriate for the average person in that firm. They don't get the average person. Some of the good risks don't choose to buy the policy. They get a preponderance of the bad risks in the firm. This means that the original rates the insurance company set, appropriate for the average, are not appropriate for the people who chose to buy the policy, and these are the ones they actually have to cover. Now, the insurance company will react to this in some way. A sensible thing for them to do will be to raise the rates—try to raise the rates in order to be high

enough to cover the people who actually choose their policy. Now, one effect of this is immediately to change the perception of the individuals who buy it about the benefit from their point of view of buying the policy. The [4-16] people for whom it was a real good deal in the first place, those who are the worst risks in the firm may still find it a good deal, but now you have raised the premium, and some of those people who were the better risks, who still found it worthwhile to choose, now may find that it's not quite so worthwhile for them. So, by raising the premium the insurance company actually serves to draw a worse selection from among the insurance pool. So, the reaction of any insurer to the problem of adverse selection of raising the rates may or may not fix the problem. It may, but on the other hand, when you raise rates you tend to draw even a worse selection from the pools. So, even thinking of just a single insurer dealing with the group of potential enrollees, the problem of adverse selection may lead to this viscious [*sic*] cycle in a way of bad risk pool, trying to raise rates to compensate it, the risk pool deteriorating, raising rates again, further deterioration of the pool until, in the extreme, it could be that there is no premium the insurer could set that would cover the costs of the people who actually buy the coverage. Now, that's the problem just from [4-17] the perspective of a single firm. Actually, in a market there will be competition among firms for coverage for individuals. And this can reinforce the tendency of adverse selection to destroy the marketability of insurance. What I mean by that is that even if a single insurer is offering a benefit that is chosen by some employees, some competitive insurance company may also have had a shot at insuring some of these people. And a competitive strategy in the context of adverse selection would be to try and draw away the good risks from the existing insurance company and leave them with the bad risks. And the way to do that is to set slightly lower benefits at less cost. That has the

effect of being more attractive to the better risks—the worse risks stay in the original pool, the better risks leave for the new policy; and this sort of competition of retracting benefits to try and keep only the good risks, in a competitive setting can lead to a retraction, retraction, retraction, until neither insurance company finds it can compete by offering any extensive benefits at all.

[4-18] Q Okay. Now my original question would be the implications of this concept of adverse selection and its effects on policy towards government mandated benefits for treatment of mental health?

A Well, this is a golden opportunity for public policy. Adverse selection can have the effect of destroying the marketability of insurance even in the case where, if the insurance companies could price the policies correctly, everybody would want to buy them. It's wrong to conclude in the context of adverse selection that if people aren't buying the policies that are offered it somehow is an expression of consumer preferences. It is an expression of consumers' desires but only in response to prices that are really inappropriate for them. These prices that insurance companies set are average prices for groups, not the true prices that would be appropriate for each individual in the group. So, when you see someone declining to buy something at a price that is way too high for them, that's not to say that they wouldn't want to buy it at they price that were appropriate to them.

That's what adverse selection can do. Now, [4-19] in this kind of context the government can step in, set a mandated minimum level of coverage which prevents insurance companies from engaging in the kind of ruinous competition for the good risks, leaving the bad risks with their competitors. That has the outcome of spreading the bad risks and the good risks around so that each insurance company can survive. It will be prevented from trying to attract just the good risks and maintain a level of coverage. And this fact changes your perspective on the nature of government intervention. Far from

being a kind of intervention that subverts consumer preferences, it's a kind of intervention that facilitates consumer preferences in a sense that the government mandate can mimic the result of a market if it were able to work correctly by setting prices appropriate for individuals. The market as it exists of adverse selection is not a well functioning market. People are being offered to buy something at prices that aren't appropriate. By mandating coverage, you can imitate the result that would have occurred had the market been able to set those prices correctly.

[4-20] Q Thank you. Now, how does adverse selection specifically relate to the subject of mental health and mandated minimum benefits?

A Let me answer that by describing exactly the circumstances in which adverse selection occurs and showing that they apply to mental health.

The ingredients for adverse selection are two. One is that the insurance company sets rates by the average in a group, and that's almost always true. The second ingredient is that the people in the group are not the average at all. Some are much worse than average, and some are less than average, and they know it. That they see that these rates which may apply to the average don't really apply to me. In the case of mental health, I may think it's very unlikely that I will ever need mental health benefits. I may be that sort of person, which is not to say that there is not some chance but if I am right about that likelihood then the appropriate premium for me, who might be a very good risk, would be quite low. And there's other people in that group who know that it's very likely that I will need to seek mental health services. [4-21] And for those people they will say, this premium is a great deal, and it may be true if their likelihood is correct that the appropriate premium for them would be quite high to cover their risk. Now, there is no doubt that this kind of thing can lead to adverse selection. Now, I think if you look at the kind of services

that are mandated by states—that state mandate insurance companies cover, it's not an accident that they include the things that they do, but the things that they include are services that are very likely to be subject to adverse selection.

Q Can you think of any other examples other than mental health that are prominent subjects of mandated intervention.

A Well, the most commonly mandated service has to do with coverage for newborns. According to Dr. Larson's paper, thirty-nine of the states mandated coverage for newborns. Now, I think that you wouldn't expect an insurance company to have anything against coverage for newborns, any more than they have anything against coverage for the mentally ill. But it is the kind of [4-22] coverage which sets up insurance companies to get slaughtered by adverse selection. Imagine yourself as being an insurance coming in to cover a firm which has young men and young women in it, and you're considering what would happen if we cover newborns. Well, you think we have to be very careful now to discriminate among, if we can, employees in the firm. And suppose we are even able to be so discriminate as to set rates that vary by the marital status of the person and by the age. Even if you are able to do this—I'm not sure you are always able to do it—you might try to set rates appropriate for young married women aged—the childbearing age—say, twenty-five to forty. But even if you do that, I think insurance companies instinctively know that setting rates appropriate for that group on average is still going to lead to adverse selection in that the people in that group, the young people, young men and women, have a good idea about whether in the course of a year or in the course of a few years, they are likely to need the benefit of coverage for newborns. And for those of the [4-23] employees who know that it is very unlikely we are going to have kids—either we don't want kids or we've had all the kids we are going to have—that kind

of coverage is useless for them. On the other hand, there will be people that the insurance company cannot identify and price separately who know that it's very likely that within the next few years I'm going to be having a baby, and the coverage for newborn care will be something that is very valuable to me. So that people will know and be prepared to make choices based upon their knowledge of their own likelihood about whether or not they want this coverage. So the insurance company can expect to get a terrible adverse selection of risk if they try to offer this kind of coverage. And all a competitor has to do is come in and offer what is an otherwise similar policy with no coverage for newborn care and the competitor is going to get all the people who are not going to have babies and the people who are going to have babies are going to go to the original company, and the results are quite predictable that they will have to bear a heavy burden in financing [4-24] the services. So, no one company can venture into this coverage without getting killed by its competitors. The only way to have it is to have this kind of competition prevented. And I would say mental health is the same case, that a company venturing unilaterally in the coverage for mental health services is likely to get the people who think and probably know that they are more likely to use it.

Q Now, from your experience have you come across any evidence that this general concept of adverse selection, as you have been discussing for a while, plays a role in the insurance market for delivery of mental health services?

A Yes.

Q Could you, please, identify the information that you examined?

A First of all, it's not a thing that—adverse selection, that is—is not something that's easy to see in the sense that if it's really powerful, if adverse selection is really working powerfully, the market is just not there. So, it's in a sense one piece of evidence for adverse [4-25]

selection is the absence of coverage for a benefit which you might otherwise think people would want. But there are circumstances under which you can observe adverse selection at work. And this is in cases where you see people making choices among insurance options and they seem to be making them on the basis of coverage for, for example, mental health services. And the place where I think it is most evident is for federal employees, who are about five million adults who have probably the best menu of choice of insurance plans of anybody in the U.S. There are two nationwide plans which federal employees may choose. One is Blue Cross-Blue Shield; one is Aetna. And within any region federal employees can choose among local insurance plans or pre-paid group practices or other things.

In 1974, Aetna, which is a commercial insurance company, undertook to review its claims experience with respect to mental health benefits. They did this because they saw their claims seemed to be high and seemed to be higher than the other carriers that were available to federal employees. They saw that their mental [4-26] health benefits were higher than they were and concluded that the reason they were higher was because of anti-selection, as they called it, but adverse selection is the same thing. They concluded that because they found that a disproportionate number of their benefits were used by people who were new to the Aetna plan. They interpreted this as meaning that people foresaw that they were likely to use mental health benefits and then selected into the Aetna plan. The Aetna coverage at this time was perceived to be slightly better than Blue Cross-Blue Shield, even though they look similar, in that they were both $100 deductible, both twenty percent co-insurance rate up a very large limit. But the—

Q Do you know what that limit was, by the way?

A I think it was $250,000. It was essentially no limit on psychotherapy.

Aetna was perceived to be better because of the amount they would pay to therapists. Blue Cross-Blue Shield paid on a usual customary fee. I think Aetna paid actually the price that the—whatever price the psychiatrist charged. So their coverage may have been slightly more [4-27] generous.

Now the response of Aetna to this review was to—they thought this problem was serious enough so that they responded in a classic way when adverse selection is present by retracting their benefits in the case of mental health services to a limit of twenty visits per year, whereas before there had been no limit at all. Now, their expenses for mental health services in 1975 went down after this retraction of benefits, but the significant thing for adverse selection is that for the first time in about four years Blue Cross-Blue Shield went up, and I think it's obvious that the effect was the people in Aetna who had been using a lot of mental health services now were no longer in a plan that covered their problem most generously so they switched from Aetna to Blue Cross-Blue Shield. And even in with the Blue Cross-Blue Shield plans, it is possible to see some indication of adverse selection. Blue Cross-Blue Shield offers two options nationwide for federal employees. One is the so-called high option, which has the deductible of a hundred co-insurance of twenty percent, limit of [4-28] $250,000. The other is the low option, which differs only in, as far as I know, a slightly higher deductible of $250 instead of $100, a slightly higher co-payment of twenty-five instead of twenty percent. I think the limit may be somewhat less also, but still nothing to constrain psychotherapy. And if you look at the utilization among people in the high option and low option whose coverage really doesn't differ that much, co-payment of twenty versus twenty-five percent is not that significant a difference. But the utilization of mental health services is vastly different in the plans. And that suggests that federal employees are alert to coverage for mental illness, have a good idea of

whether or not they are likely to use the services, and are prepared to choose the plan on the basis of the one that gives the best coverage for them. And that's evidence of adverse selection.

Q Okay, now to take us back to square one for a second. You originally identified I think three factors which you, I think, described as deficiencies, or problems which inhibit the delivery of mental health services by the insurance mechanism.

[4-29] The first was adverse selection. The second I think you said was the fact that the benefits which accrue from treatment for mental and nervous conditions extend beyond the individual who seeks the services. Could you explain what you mean by that second factor?

A Yes. The first adverse selection referred to the insurance market itself. The second one, the fact that the benefits of receiving mental health services go beyond the individual who receives them, has nothing to do with insurance per se, but about the market for services. And it is simply that when someone uses mental health services the benefits of them doing that appear not to fall just upon the individual user who may feel better because of it but upon society as well.

If I could just quickly give an example of another case of this—pollution is an example of, instead of a benefit, a cost that society bears of some individual or corporate action. If a steel maker is making cars and they dump some effluent in Lake Erie, then one of the—some of the effects of their activity fall upon [4-30] wider population groups, and society responds to this either by prohibiting activity outright or by taxing it to—as an expression of society's interest in the activity.

Q Now, with respect to mandated minimum mental health benefits, what specific additional social interests, I guess as you call them, are certain?

A Well, I would identify two. One is an interest the society and the people in society have in the well being of other people—of people who may be mentally ill. And

that's just some compassion involved in that one. That's not one that I consider myself having special expertise with respect to. The other one which I would identify is that apart from a personal interest in someone else's welfare, the way mental illness is manifest in our society and the way we pay for those manifestations is something that builds in a collective interest in each individual's mental problems. Now what I mean by that is that if you think by not covering insurance—not covering payment for services directly related to mental illness —that somehow we avoid the collective burden of mental illness, now, I think that is basically [4-31] incorrect.

Q Why is that?

A In 1975, eight hundred thousand people were treated in public mental hospitals for mental illness. Nine hundred thousand people were treated in general hospitals as diagnosed as being mentally ill. Thirteen million people were treated by the general medical sector, by private physicians who are not psychiatrists, where primary diagnosis was mental illness. Two hundred thousand people were kept in nursing homes where they were diagnosed to be mentally ill. Three hundred and fifty thousand people were in VA hospitals treated for mental illness. Community mental health centers treated some couple million, 1.5 million people. Now these services are not paid by the individuals who use those services. Taxes support public mental hospitals. Taxes support community health centers. Medicaid pays for care in nursing homes. General insurance, commercial and Blue Cross-Blue Shield pays for care in the general medical center by private physicians and in hospitals. So these are—this set-up builds in an inter-dependence [4-32] among people in the problem of mental illness.

Now, if I can just add to that a bit—

Q We will have to stop you, just to ask you to back track for a second. You mentioned that there were thirteen million people who were with mental and nervous conditions treated by physicians, and I ask you to identify

what implications that particular mode of treatment has for government policy with respect to mandated benefits for treatment of those conditions?

A I think I can do that. I think it's a more general answer, but an implication is that according to the President's Commission on Mental Health, which was completed in 1978, general physicians, that is, general practitioners, internists, others, are not adequately trained to deal with problems of mental illness; so what you have is people who have problems going to seek help from the general medical sector, private physicians trying to help them in the ways that they have been trained to help, which are basically giving them drugs and doing surgery on them. And it is not clear that this is the appropriate way [4-33] to deal with mental problems. It may be more appropriate to deal with them more directly as psychological problems by specialists in mental health rather than by people trained in physical health problems. That's true with respect to private physicians, and it's also true when mental health problems are manifest and dealt with outside of the mental health sector.

Q Doctor, has there been any empirical research that has tried to quantify or confirm whether increasing the availability of mental health services has some off-set or reducing effect on other medical expenses?

A Yes.

Q Would you, please, explain the history of some of that research?

* * * *

[4-36] Q Dr. McGuire, I think we left off with the question has there been any empirical research to confirm the extent to which an expansion of the availability of mental health care would result in a reduction in expenditures for other medical care?

A Yes.

Q Are you familiar with that research?

A Yes.

Q Doctor, based upon your experiences as an economist in the health care field, further on your research in connection with your forthcoming book on psychotherapy, and further on your experience as a member of the review panel on the efficacy and cost effectiveness of pschytherapy for the United States Office of Technology Assessment, and further on your membership of the review committee—the Epidemiologic and Services Research Review Committee of the National Institute of Mental Health, do you have an opinion as to whether the expansion of the availability of [4-37] services for treatment of mental and nervous conditions reduces medical expenditures for physical care?

A Yes.

Q What is that opinion?

A I think there is a significant offset of medical expenditures when mental health services are provided.

Q Could you be more specific on the nature of the offset?

A Studies have revealed that—most of the studies report offsets—

MR. GREENFIELD: Objection.

THE COURT: No, I'm going to sustain it.

Q Doctor, do you have an opinion as to whether there are any dangers or pitfalls associated with the government mandating that insurance companies provide treatment benefits—benefits for treatment of mental conditions?

A Yes.

Q In your opinion, what would those dangers be?

A I think there's two major dangers. One is that, as a result of mandated insurance coverage, people [4-38] will use a lot more of the services, and it will cost a lot of money to provide them. The second danger is, in the case of mental health services, that the state mandate coverage for a service that is used by a small portion of the population, possibly by members only of the upper income groups, in which case the policy would effectively

redistribute purchasing power from the general taxpayer, general workers, to members of the upper income groups.

Q Okay, now. With respect to the first danger that you mentioned, increased demand and cost, could you elaborate on what you mean by that?

A Sure. I think it's important to keep in mind when you start discussing cost and its implications for policy to distinguish between costs that represent simply a shift in the way something is paid for and between that and an actual increase in the total amount of cost that society is bearing as a result of insurance legislation. The first thing is not worrisome at all; the second thing may be.

For example, if you take a look at the experience of Blue Cross-Blue Shield in Massachusetts before and after the mandated minimum mental health [4-39] legislation, they report that—

MR. GREENFIELD: Objection.

THE COURT: Sustained.

Q Doctor, are you familiar with the experience of Blue Cross-Blue Shield with respect to expenditures for treatment of mental and nervous conditions, both before and after state legislation mandated such benefits?

A Yes.

Q What was that experience?

MR. GREENFIELD: Objection.

THE COURT: I'll allow it.

A Before 1976, expenses covered for mental conditions were approximately $5- or $700,000 per quarter. After 1976, in 1978, specifically, expenses were about $7 million per quarter.

THE COURT: Could I have that first figure again? I'm sorry.

THE WITNESS: $500,000.

THE COURT: $500,000? Thank you very much.

THE WITNESS: That's approximate.

Q Now, what are the implications of those before and after figures for the increased cost danger [4-40] to this legislation that you've mentioned?

A You don't know, just by looking at the figures, whether or not they represent simply a shift in who's doing the final payment for the services or whether they represent an increase in the amount of mental health services being provided. If all that's being said is that before 1976 we didn't offer this benefit and, therefore, it didn't cost us very much and after 1976, yes, we did offer this benefit and lo and behold, it does cost us something, then that's not saying that society in any sense is paying more for mental health services. It's just that the people aren't paying for it directly any longer, but they're paying premiums to the insurance company who then pays it to the providers. That may be experienced as an increase in the cost to the insurance company itself, but its's not an increase in cost to society. It's simply a transfer.

Q Well, is there any way to assess the extent to which increased insurance expenditures represents added costs or a shift in costs?

A Yes.

Q How could that be done?

[4-41] A Well, you can't do it, first of all, you can't do it by looking at simply by looking at the claims experience of Blue Cross. To do it you need to be able to compare what people did before they had insurance coverage to see how much they spent on mental health care and compare that to what they did afterward. By just seeing the total claims that Blue Cross paid, you only see the second thing; that is, how much they use after they have insurance. You lack the baseline by which to make a comparison. But there has been research in mental health that has investigated that, some of which I've done myself and the rest of which I reviewed for the National Institute of Mental Health in my paper, "Financing and Demand For Mental Health Services."

Q And from that work, have you drawn any conclusion, with respect to the added costs and shifting costs dichotomy?

A Yes.

Q What was that conclusion?

A With respect to the added costs? I should say, first of all, that the research in the area of the effect of insurance on utilization of mental [4-42] health services is not nearly so well developed as it is in the case of insurance on general medical services, in which research has been going on for a longer time, in which there's been more of a settling of exactly what's happened. So it's impossible to make a large number of detailed conclusions, but there are some things you can say with confidence, and those, I think, are important for consideration of mandated mental health benefits.

Q And what are those?

A The first thing would be an obvious one, I think, to an economist but is worth saying anyway, and that is, demand is not unlimited; meaning that, no matter how much insurance you give people, they're not going to go out and spend all their time receiving therapy. There was some concern evident in the policy literature that if you give people insurance for something, they'll go wild and spend half their income on receiving psychotherapy or other mental health services. But that's not the case. However, it is the case that the responsiveness to insurance of demand for mental health services is greater than it is [4-43] for general medical services. And to be specific about that, take the case of the demand for outpatient services, say the services of a physician in private practice, as compared to a psychotherapist in private practice. Generally, research in health services finds that if you increase the amount of insurance coverage a person has by about 1 percent, meaning that if, instead of having co-payment of 50 percent, they now pay only 49 percent—if you imagine a little experiment of giving them a little bit more insurance, the response is to that 1 percent increase in insurance to increase the utilization of services by about .5 percent. So that they do increase. When people have insurance they do tend to buy more of the physician services, but they don't increase it very

much, only about half as much as the increase in the insurance coverage itself. If that's compared to the demand for mental health care on an out-patient basis, it's less. That is, the demand for mental health services is more responsive to insurance than is demand for general medical services. The findings from my research is that if you increase insurance [4-44] to someone by 1 percent, on the average the increase in demand is 1 percent more greater, or slightly greater. So, it's considerably more responsive than the demand for general medical services.

Q Okay. You've identified the potential for an increase in demand as a result of an increase in insurance coverage. What are the implications of that phenomenon for government policy, with respect to mandating minimum mental health?

A Well, it means you have to be careful, that it is possible that if you go too far and include a great deal of mandated insurance coverage, then people will respond to that large increase in insurance with a significant increase in demand. Now, I want to interject at this point that some increases in demand appear to be appropriate, based on my testimony so far. But, it's important to recognize that you can go too far and include too much insurance coverage and get into increases in demand which may not be warranted. But, in order to be prudent, I think it is prudent to set a relatively strict limit on mandated benefits, such as $500.

[4-45] Q As in Massachusetts?

A As in the case of Massachusetts.

Q Are there other control mechanisms that can be utilized, either by the statute or by insurance companies, to control utilization and demand?

A. Yes.

Q Will you give us some examples?

A Well, putting a limit on the total liability of insurance companies is one way to limit demand. Other ways are by deductibles, which are payments to be made by the insuree before the insurance company benefits can

begin. Co-payments, which means that the insured pays some portion of the cost along with the insurance company. Claims review on the part of insurance companies to investigate which claims appear to be legitimate and worth paying. Peer review mechanisms are possible—a whole series of things can be done.

Q Okay. You mentioned co-payments. By that, you mean that for each visit a client or a consumer has to pay a certain percentage of the fee?

A Either a percentage or a fixed amount.

Q Or a fixed amount. Do you know whether Blue Cross-Blue Shield in the experience that you [4-46] mentioned you're familiar with imposed a co-payment requirement on their clients?

A I believe they don't.

Q Are there any specific evidence that you have utilized in the course of your research concerning the actual cost of mandated benefits for the treatment of mental health?

A Yes.

Q What are the costs, or how would you—

MR. GREENFIELD: Objection.

THE COURT: Sustained, as to form.

Q Now, you've also mentioned that a second danger besides increased cost and demand, and that was, I think you were referring to what I would describe as a distributional effect?

A Yes.

Q Could you elaborate a little bit more on what you mean by that?

A Okay. The idea is that you're providing a benefit to society and you're requiring a certain portion of society to pay for that benefit. The concern is that the people who use mental health services might come from a portion of society—the fear being, specifically, that they are people only [4-47] with a lot of education and a lot of money that will be the people who benefit from this

care, and the people who pay for it are sort of the average worker.

Q Now, in the course of your experience have you had occasion to study or consider the likelihod that that effect will occur or has occurred?

A Yes.

Q And have you reached an opinion?

A Yes.

Q And what's that opinion?

A My opinion is it won't occur in the case of the Massachusetts statute.

Q And why is that?

A First of all, my work on the effect of insurance coverage on demand for out-patient psychotherapy focused on the question of the distributional impacts of this because it is a serious problem in this policy and with respect to many other areas of mental health. And I investigated the extent to which different income groups respond to insurance coverage. I broke down the responsiveness by what the people in the top quarter of the income group do, what the third quarter and [4-48] the second and the first quarter. And my finding was that for the people who have the greatest amount of income, the responsiveness is very low to insurance coverage. It doesn't seem to make much difference at all to them how much is paid for insurance. But if you look at the responsiveness as it changes as you go down the income groups, the responsiveness increases, so that the responsiveness by the people at the bottom is much greater than the people at the top. The consequence of this is, after you provide insurance coverage the distribution of services is going to tilt, tilt away from the people whose demand is about the same towards the people whose demand has increased, and those people will be the people on the bottom rather than the top of the income group.

Secondly, I think the $500 limit is an effective way of stopping a lot of utilization by the people at the top who may be inclined to go into psychoanalysis, or

other insight-oriented therapy, that might not be used by the people near the bottom of the income scale.

And thirdly, the statute covers settings [4-49] in which the people who don't have a lot of income, that those are the settings that these people use. Community mental health centers, for example, are used by—or, more than half of the people seen in community mental health centers fall below the official poverty line. So, these are settings which, I think, either make an effort or people respond to them from both the lower, primarily the lower income groups in society.

Q Thank you. Doctor, have you had an opportunity to review a report entitled, Mandated Health Insurance Coverage and Study of the Review Mechanisms by Dr. John Larson?

A Yes.

MR. MONTGOMERY: If there's no objection, I'll provide a copy to the witness of the report.

Q Referring to page, beginning on page 67 of that report, which is marked as Exhibit 18 in this record, the section entitled, Conclusions—I guess really continuing on page 68 and 69—Professor Larson draws two conclusions. Would you care to comment on the first conclusion that he made?

A My comments on the second one would be quicker. [4-50] Q Okay.

A The second one, that each must receive an exhaustive examination as each proposal for mandated mental health benefits, I think, is a sensible one, and I would hope that any legislature would adhere to it.

Q Okay. And with respect to the first conclusion?

A The first one—I don't know if everyone has a copy—which is to place a moratorium on this kind of policy and then, if done, only to do it as an option, I am not convinced by.

Q And why is that?

A Well, first of all, if you consider the pluses and the minuses of this kind of policy, I think Dr. Larson

didn't give enough weight to the possible pluses. As I've testified already, I think adverse selection is a very important argument in considering mandated minimum benefits for mental health or for others, and although he mentions it at some point in this document, it's not given the weight that I would in considering the possible positive effects.

And secondly, there's no discussion that I can recall here about the possible offset [4-51] effects of a mandated service. And while this report was oriented toward the more general problem, I think of you're going to make a general recommendation, you'd be obliged to cover all the possibilities.

Q Thank you. I'd like to show you—

A Excuse me. I would have some more to say, though. That's on his neglect of what I consider the positive arguments. He also mentions the possible drawbacks of mandated mental health benefits, and this is my list. He uses the same dangers that I do. One, it's going to cost a lot. And, two, that it might be distributionally harmful. Although I think that these are the right issues, to assess the importance of an objection, he needs to martial some evidence to say how important it is. And my opinion about his evidence is that it is weak, very weak.

Q Thank you. Do you have any further comments on the two conclusions in the report?

A No.

Q Now, I'd like to show you what has been marked as Exhibits 22 and 23 in this case. And I'll ask if you've had an opportunity to review those [4-52] exhibits.

A Yes.

Q And do you understand the methodology that Professor Larson used—

A I think so.

Q —creating those exhibits. And Exhibit 22 is his calculation of nationwide additional premium cost for mandated benefits legislation.

A Yes.

Q Based on the Colorado experience; is that correct?

A Yes.

Q And Exhibit 23 is a similar projection, based upon the Maryland experience; is that correct?

A Yes.

Q Now, are you familiar with the accepted methods of projecting the economic consequences from an individual set of data from one market?

A Yes.

Q And do you have an opinion concerning the correctness of Dr. Larson's methodology?

A Yes.

Q And what is that opinion?

A I don't think it's very enlightening.

Q And could you elaborate on why it's not enlightening [4-53] in your view?

A Well, as I understand the methodology, it is taking the behavior in a small setting. By what I mean by that is, Item A on Exhibit 22, which represents a rate of utilization—$91 per person per year means that they are going to be using, anticipated using $91 worth of services per year. It takes this rate of service utilization and multiplies it by the number of people to whom it's supposed to apply, and this is now a national figure of the number of people. And then, by multiplying A times B, you get a national rate of utilization. Well, it seems to me that what this is is simply basing a projection on what will happen in a market solely on demand side of that market. That—one of the very important lessons in economics is that market outcomes are determined not just by demand behavior but by demand and supply behavior together. So, in a market you need to take into account not only demand considerations but also supply considerations.

THE COURT: Excuse me one moment, please. Okay. Go ahead.

Q Now, specifically with respect to the supply side [4-54] of the market for treatment of mental and

nervous conditions, have you had an opportunity to study the supply of mental health treatment providers?

A Yes.

Q And specifically, what's been involved in the study that you've done?

A Well, partly, I studied it in the course of my book. One of the papers that I've written, Market for Psychotherapy, has a section on the numbers of providers of different types and the projections of those numbers for years ahead and the consequences of some of those projections for different kinds of policies. But it involved seeing how many people are out there and how it's likely to change in the next couple of years.

Q And, Doctor, have you been able to calculated from the use of Exhibit 22 and from Dr. Larson's figures, I believe, on page 35 of Exhibit 18—36—the portion of his $5 billion projection represented by mandated mental health benefits?

A Yes. And this is somewhat approximate, but what I did was to take the portion of the $91 that is represented by coverage for nervous and mental conditions on page 36 of his report, which works [4-55] out to be roughly one-fifth. Nineteen is the portion that has to do with what our concern is here, and that is roughly one-fifth of the $91. So, it's simply by multiplication that one-fifth would also apply to the total.

Q There's roughly a billion dollars is what's involved?

A Roughly a billion dollars is what's involved.

Q Now, from your experience and from your study of the supply of providers of mental health treatment do you have an opinion as to whether there are in the United States a sufficient number of providers to meet, today, the $1 billion demand, if there were mandated mental health benefits in each of the fifty states?

A No, I don't think there is.

Q Do you have an opinion as to the extent to which the supply of providers would have to increase in order

to meet an assumed demand consistent with the $1 billion insurance expenditure?

A Some back of the envelope-type calculations suggest that we'd have to have roughly four times as many psychiatrists and others in business to be able to meet these projections.

* * * *

CROSS-EXAMINATION
BY MR. GREENFIELD:

[4-68] Q Is there any reason to believe that the mental health needs of persons covered by uninsured plans are any different than the mental health needs of persons covered by insured plans?

A I wouldn't think so.

Q You wouldn't think so?

A It's hard for me to assess needs, as I said, I couldn't.

Q As an economist have you ever heard the term, "There's no such thing as a free lunch"?

A Yes.

Q I'm sure you have.

A That's one I know.

Q Could you explain what that means?

A It means that if you're going to get something that has any scarcity value in society at all, then it's going to be paid for, even if not necessarily in cash—and that's the point of the whole statement—even if you don't think you're paying for the pretzels you go to a bar to get, it appears like it's a free—actually, [4-69] the expression came from a free lunch at a bar—that there's no such thing as a free lunch, even though it may appear to you; you pay for that free lunch either through higher prices of a beer or some other way.

Q Yes. And there's no such thing as a free benefit, a free health benefit?

A Well, if you could ask that in a way that—

Q You can't answer it the way I've asked it?

A Well, I think I'll agree with you, but I'm just not comfortable with the way you've asked the question. If

the health benefit involves resources used that have no value elsewhere, then it could be provided without any other cost. So, I—if you could ask it again, maybe I could give you a satisfactory answer.

Q Since you can't answer that, let me try something else. Assume that here's an ERISA plan. You now have some idea of what that is?

A I'm coming to learn.

Q Yes. Assume that there is an ERISA plan with a finite amount of resources.

A Meaning what?

Q Meaning it has just so much in the pot. There's [4-70] so much funds available between the employers and the employees.

A Okay.

Q And assume that the employers and the employees have decided as to how they want to allocate those resources between various types of health benefits, okay?

A Okay.

Q Now, if they've got to spend more for mental health because of a mandated statute, that means they're going to spend less for something else.

A That's subtraction.

Q Yes.

A Okay.

Q The pie is just so big, and if you cut one piece bigger, there's going to be just that much pie left.

A Which, of course, depends on your assumption that the pie is fixed.

Q Yes. Isn't it your understanding—well, I guess, you don't have an understanding—strike that. And as the pie becomes smaller because of administrative costs going up, there'll still be less for other types of benefits, won't there?

[4-71] A If the pie shrinks, there's less for everything.

Q Now, you gave an opinion concerning the relationship between expenditures for mental health and, if I understood it, reduction in other health costs?

A Yes.

Q And when you began that opinion or when you were questioned about that, you were asked whether the opinion was based upon prior research in that field.

A I don't recall being asked that, but I guess we could find out soon enough if I was.

Q Well, can we concede that that was part of the question? Well, did you rely upon prior research in the field?

A By whom?

Q By anybody.

A Yes.

Q Would you characterize that research as weak?

A Some of it.

* * * *

CROSS-EXAMINATION
BY MR. McGOVERN:

[4-77] Q Doctor, assume for purposes of this case that a lot of other states were to pass a mandated benefit law similar to the Massachusetts mandated law.

A Yes.

Q Would you at least go along with this to the extent of projecting that this would result in a very substantial increase in the cost of mental health care across the country? I'm talking—you can talk in terms of shifting or addition; I don't care which it is.

A Well, I think you have to, and I will. That you have to talk in terms of how much of an additional coverage this means to people in different states, and then based on that, how much additional services are likely to be used.

Q Wouldn't you say that at least you're talking in [4-78] terms of millions of dollars? I mean, you won't go up to a billion, but you're talking millions of dollars in this?

A I would expect, yes.

THE COURT: Could I ask a question? Would that be in addition, a million, or would it be a shift?

THE WITNESS: I would think the additions would be in the millions of dollars.

THE COURT: Okay.

THE WITNESS: Wait a minute—yes, I'm comfortable with that.

Q And, in fact, it would be in the terms of millions of dollars, wouldn't it, very likely?

A These are getting to be numbers that I don't want to respond to so quickly. If you're going to say millions, I would go along; tens of millions, I would like to sit down and think about it.

Q But you wouldn't rule it out, sitting here right now, would you?

A No.

* * * *

REDIRECT EXAMINATION
BY MR. MONTGOMERY:

[4-83] Q Now, you commented on some of the conclusions drawn by Dr. Larson. As I recall, on direct examination you testified that the evidence in support of his recommendation that mandated benefits should be allowed only as an option, you said the evidence was weak. Would you elaborate on what you mean by "the evidence is weak?" Would you elaborate on that conclusion?

A Well, the two dangers of mandated minimum mental health benefits that Dr. Larson pointed out in his report, whereas I said the ones that I talked about as well, these were: That it would cost a lost, first of all, and that it would have unfortunate distributional consequences. Now, with respect to the cost, the only evidence I saw [4-84] that was cited in Dr. Larson's report are the estimates by Blue Cross and Blue Shield of what they would expect it to cost in Colorado and what they would expect it to cost in Maryland. And having no knowledge about how those estimates were formulated I consider them as having more the appearance of evidence than the substance of evidence since they are numbers—in that sense they are evidence—but, not knowing

how to judge those numbers, whether or not they were made sensibly or on what basis of experience, if any, they were derived, I consider that evidence weak. The other danger has to do with the distributional effects, and the only evidence marshalled in that case is one sentence which refers to the alleged known unfortunate distributional effects of Medicare and Medicaid. And my understanding of the distributional effects under those programs is that it has not at all been unfortunate but they have done what they were supposed to do, to make sure the poor have resources in order to pay for care which has been done, and similar with elderly people. I think no one that I know of is seriously suggesting that we reconsider Medicare [4-85] and Medicaid on the basis of distributional problems.

Q If the mandated benefits were required only as an option by various state legislatures that have considered the question, would that avoid the problems of adverse selection?

A Not at all. It must be compulsory to avoid adverse selection.

* * * *

[4-87] Q Now, you mentioned on cross-examination, health maintenance organizations, or HMO's. Can you identify an HMO that you're familiar with in the Boston area?

A Well, I'm a member of one, the Harvard Community Health Plan.

Q In general, what role do HMO's play in the marketplace for delivery of health services?

A Well, they provide an alternative form of protection against health expenses. By joining an HMO, a member pays enrollment fees which are much like a premium from the point of view of the member, [4-88] and in exchange for the fees, the individual receives services directly from the organization rather than through a third party which would then collect the mass premiums to pay off the providers. But from the individual's point of view, its an alternative to health insurance.

Q Do you know whether HMO's provide services for treatment of mental or nervous conditions?

A Yes, they do; they must.

Q And do you know why?

A The HMO Act of 1973 included mental health services among those that HMO's were mandated to offer in their benefit package.

* * * *

EXHIBIT 3

IUE-AFL-CIO-CLC

May 16, 1979

HEALTH INSURANCE

General Electric

1. Provide 100 percent payment of all medical expenses after an employee has $1,000 out-of-pocket family medical expenses in a year for one illness.
2. Eliminate the Major Medical maximum amount and cover all expenses including surgical centers, nursing homes, recovery facilities, and replacement of necessary or required prosthetic appliances.
3. Provide for mental and nervous disorders to be paid the same as any illness including alcohol and drug rehabilitation treatment and treatment by a licensed social worker.
4. Reduce the family deductible under Major Medical to $100 per year.
5. Provide complete company payment for insurance for employees and dependents and retirees and dependents and for medicare—Part B.
6. Provide insurance coverage for employees and/or their dependents in the event of death, disability, or lay-off equal to their years of service with a minimum of two years.
7. Provide full payment for up to two hearing aids during a three-year period if prescribed by a physician and unlimited repair of hearing aids.
8. Extend full medical coverage to all retirees and their dependents.
9. Provide for payment of the private room rate if it is the only accommodation available or ordered by a doctor.

10. Provide the usual and customary doctor's fees for operating schedule and maternity.
11. Provide payment for emergency treatment for accident or illness for doctor and facility whether provided by a hospital, clinic, or by a special group or individual doctor.
12. Provide full payment for consultation or confirming opinion.
13. Provide full coverage for in-hospital doctor's visits.
14. Provide full payment for diagnostic coverage wherever performed.
15. Cover child from birth for all benefits automatically.
16. Provide dependent coverage for parents who are dependent on an employee for support.
17. Provide for an annual open enrollment period for dependents not previously covered.
18. Provide a common insurance carrier for all health insurance benefits.
19. Provide full payment of administrative charges.
20. Make all benefit programs subject to the grievance procedure and arbitration.
21. In the event that uncontested medical claims for coverages under the plan are not reimbursed by the carrier within a period of four weeks, the company should make direct payment to the medical provider, and the collection of the claim will thereafter become the responsibility of the company.
22. Provide that a written statement by an employee's doctor as to an employee's health or ability to work shall be controlling in determining his or her entitlement to Medical Care, LTD Benefits, and Disability Pension.
23. Provide coverage in the event of strike, walkout, etc.
24. Remove reference to temporary employees from the plan and provide coverage.

EXHIBIT 5

EXHIBIT D

GENERAL ELECTRIC

INSURANCE PLAN

As amended July 1, 1979

ERB 799.1

Indicates July 1, 1979 Modifications
(Effective dates indicated in Text)

[SEAL]

METROPOLITAN LIFE INSURANCE COMPANY

A Mutual Company Incorporated in New York State

(Herein called the Insurance Company)

Group Insurance Certificate

The Insurance Company certifies that it has issued Group Policies Nos. 663-G and 17500-G insuring the Employees of

General Electric Company

(Herein called the Employer)

under which certain Employees are insured on their own account and on account of their eligible Dependents for benefits as described on the following pages of this Insurance Plan Certificate-Booklet for Plan ERB-799.1.

If you are an Employee, as defined in this Certificate-Booklet, you will become insured on your own account and on account of your eligible Dependents in accordance with the provisions set forth in this Certificate-Booklet under the caption "Eligibility and Effective Date."

The Plan described in this Certificate-Booklet is not applicable prior to July 1, 1979.

The Contributory Insurance described in this Certificate-Booklet, is applicable only if you (1) have requested, (2) are insured and (3) are making the required contribution for benefits under such insurance.

This Certificate-Booklet is valuable to you and should be kept in a safe place known to you and your beneficiary. If you lose your booklet, an additional copy may be obtained from your employer.

This Certificate-Booklet contains those provisions of the Group Policy which affect Employees who are insured.

It is not a contract of insurance. The insurance is subject to the provisions of the Group Policy which constitutes the contract under which the insurance is provided.

No agent has authority to accept or waive the required proof of claim, nor to extend the time within which such proof must be given.

There is certain further information relating to your insurance on the next page of this Certificate.

This Certificate-Booklet is non-assignable and the insurance and benefits are non-assignable prior to a loss. The insurance does not at any time provide paid-up insurance, or loan or cash values.

METROPOLITAN LIFE INSURANCE COMPANY

/s/ Richard R. Shinn
RICHARD R. SHINN
President and
Chief Executive Officer

This Certificate-Booklet Replaces All Previous Certificates and Booklets Issued to You by Metropolitan Life Insurance Company Relating to Any Coverages Summarized Herein.

HEALTH INSURANCE CONVERSION PRIVILEGE

In the event of cessation of your Comprehensive Medical Expense Insurance because of termination of your service with the Company for any reason, you may arrange to obtain from the Insurance Company, without furnishing evidence of insurability, an individual policy for yourself or, if at that time you had insurance for your dependents under the Insurance Plan, an individual policy for yourself and such dependents in accordance with the following conditions. The individual policy may provide, at your option, Hospital Expense Insurance, or Hospital Expense and Surgical Operation Insurance or Major Medical Expense Insurance or similar type of policy then being issued for conversion purposes by the Insurance Company, subject to the requirements of any applicable laws and regulations relating to the issuance of such insurance. The individual policy may be obtained by making application to and paying the required premium to the Insurance Company within thirty-one days after cessation of your Comprehensive Medical Expense Insurance, and shall become effective upon cessation of such insurance under the Plan.

At the option of the Insurance Company, the individual policy need not provide benefits in excess of those under your Comprehensive Medical Expense Insurance. The individual policy may provide (a) for the exclusion of any condition excluded by your Comprehensive Medical Expense Insurance but not any other pre-existing condition, (b) for reduction of benefits thereunder during the first year to the extent that benefits will not exceed those that would have been provided had your Comprehensive Medical Expense Insurance not ceased; and (c) for reduction of benefits thereunder by any benefits payable under your Comprehensive Medical Expense Insurance after such insurance has ceased.

The Insurance Company will not be required to issue the converted policy covering any person if it is indicated

that, at the date of termination he has similar coverage, or is eligible on a group basis for similar coverage, which together with the converted policy would result in overinsurance or duplication of benefits. The converted policy may provide that the Insurance Company may request, on any premium due date of such policy, information, concerning the existence of similar coverage on any person covered thereunder, and if any such person fails to furnish details of such coverage when requested may take such coverage into account in determining benefits payable under the converted policy.

Your dependents may apply for individual policies if they do so within thirty-one days after their coverage is terminated because they cease to be a dependent as defined on page 12 hereof, unless such termination was at your request, subject to the above provisions.

The converted policy shall also be available to your divorced spouse or former spouse in the event of annulment of your marriage, upon the divorce or annulment of the marriage while your spouse is covered as a a Dependent.

NOTICES TO EMPLOYEE

If you cease active work for any reason, you should find out from your employer what arrangements, if any, can be made to continue your insurance benefits in force, so that you will be able to exercise any rights you may then have.

If an individual policy of Life Insurance has been issued to you in accordance with the Life Insurance Conversion Privilege described in the Plan, payment with respect to the Life Insurance under the Plan shall be made only if such individual policy is surrendered to the Insurance Company without claim thereunder. The designation by you of a beneficiary under an individual policy of Life Insurance issued in accordance with the Life In-

surance Conversion Privilege, other than the beneficiary of record under the Plan, shall effect a change of beneficiary under the Plan to the beneficiary of record under such individual policy, regardless of whether or not written notice of such change is filed with the Employer.

The Home Office of the Insurance Company is located at 1 Madison Avenue, New York, New York, 10010.

GENERAL ELECTRIC INSURANCE PLAN
With Comprehensive Medical Expense Benefits
As Amended July 1, 1979

The provisions of this Plan are applicable to employees in all States. For employees employed in the States of California, New Jersey, New York, Rhode Island, and Hawaii and the Commonwealth of Puerto Rico, the Weekly Sickness and Accident Insurance described in this Plan will be adjusted to take into account any similar benefits provided for them pursuant to the laws of such jurisdictions. Such employees will receive an appropriate supplement to this Plan describing the benefits provided pursuant to said laws and the applicable modifications in the benefits and contributions set forth in this Plan.

LIFE INSURANCE

(For Employees)

As a participating employee, the amount of your Life Insurance until you reach age 65 will be two times your normal straight-time annual earnings. This amount will vary with changes in such earnings. However, if, at the time of death prior to age 65, the amount of your Life Insurance is based on earnings which are lower than your highest normal straight-time annual earnings at any time during the five years preceding the date of death, then the highest normal straight-time annual earnings during such five year period will be used in determining the amount of your Life Insurance. For employees whose regular work schedule is 35 hours per week or more, the minimum amount of life insurance prior to attainment of age 65 will be $15,000 (effective January 1, 1980, $20,000).

If you continue in Company employment beyond the end of the month in which you reach age 65 and your death occurs before your continuity of service is terminated,

the amount of your Life Insurance will be based on your normal straight-time annual earnings reduced by an amount equal to 1.1% of such insurance times the number of calendar months that have passed since the end of the month in which you reached age 65, including the month of your death. When your continuity of service terminates other than by death, the amount of your Life Insurance will be subject to immediate reduction to an amount which would have applied to you in accordance with the provisions set forth in the paragraph entitled "Benefits After Retirement or Termination of Employment at Age 65 or Later" had your service terminated at the end of the month in which you reached age 65.

In the event of your death from any cause, the amount of your Life Insurance then in force will be payable to the beneficiary designated by you. You may change your beneficiary at any time. Any designation of beneficiary or any change of beneficiary should be made in a form acceptable to the Insurance Company and must be filed with the records maintained by your employee relations or personnel accounting office. Upon request, such office will furnish you with a copy of your designation of beneficiary.

Upon receipt of written notice of change of beneficiary by such office, the change shall relate back and take effect as of the date you signed such written notice, whether or not you are living at the time of such receipt, but without prejudice to the Insurance Company on account of any payment made before receipt of such written notice.

If, at your death, there shall be more than one designated beneficiary, then, unless you shall have specified the respective interests of such beneficiaries, the interests of such beneficiaries shall be several and equal. If any designated beneficiary shall die before you, the rights and interests of such beneficiary shall thereupon automatically terminate. If at your death there is no beneficiary of

record as to all or any part of the insurance, then the amount of insurance payable for which there is no such beneficiary shall be payable to your estate, or the Insurance Company may, at its option, pay such amount to any one or more of the following surviving relatives: spouse, mother, father or child, which payment shall completely discharge all liability with respect to the amount of insurance so paid.

If your Life Insurance is payable in a lump sum to an adult beneficiary upon your death, the Company, in accordance with its normal policies, may make an adverse payment of up to $500 from the Life Insurance proceeds.

If you prefer, instead of having your Life Insurance paid in a lump sum, you may arrange to: (1) have it paid to your beneficiary in monthly or annual payments (a) over a fixed period of years or (b) during the lifetime of the beneficiary; or (2) have it held at interest for a limited period and then paid in a lump sum or in installments. If you wish, your beneficiary may elect any one of these optional modes of settlement in lieu of a lump sum settlement or in lieu of another optional mode which you may have elected during your lifetime. The Insurance Company will, from time to time, determine the minimum amounts of installments payable as well as the rate of interest to be used in calculating the amount of payments under the optional modes of settlement.

Benefits after Retirement or Termination
of Employment at Age 65 or Later

If you retire from the Company on pension prior to age 65, or if you leave the service of the Company after you are entitled to optional retirement under the Company's Pension Plan, or if you leave on a retirement allowance granted by the Company, your Life Insurance will be continued in full force up to age 65.

Whether you retire prior to age 65 or your continuity of service terminates after age 65 or later, the amount of your Life Insurance will be reduced monthly, commencing on the first day of a calendar month following your 65th birthday, by an amount equal to 2½% of the total amount of Life Insurance in force on your life when you attained such age. These reductions will continue until the amount of Life Insurance is equal to the ultimate amount shown in the following table. If your death occurs after you reach age 70, up to the first $5,000 of the ultimate amount will be paid by the General Electric Insurance Plan Trust as a benefit in lieu of Life Insurance (the "Trust Death Benefits") and any portion of the ultimate amount which exceeds $5,000 will be paid by the Insurance Company as Life Insurance. However, if you or your spouse receives medical expense benefits in lieu of Life Insurance, as described on page 8, the ultimate amount will be further reduced by an amount equal to such medical expense benefits, and the reduced amount will be paid in accordance with the foregoing sentence. Notwithstanding any other provision of this paragraph, if (i) at age 70 you have made an irrevocable assignment of your Life Insurance, (ii) you have mandatorily deferred incentive compensation, or (iii) you retired from the General Electric Credit Corporation or one of its affiliates, your entire ultimate amount will be payable as Life Insurance.

ULTIMATE AMOUNT OF LIFE INSURANCE AFTER AGE 65 OR THE DATE OF YOUR RETIREMENT, IF LATER*

Period for which you have been insured immediately prior to age 65 or the date of your retirement, if later, under this Plan	Your ultimate amount of insurance **
10 years or more	33⅓% of your average amount of Life Insurance during the highest consecutive 5 years in the 10-year period
9 years	30% of your average amount of Life Insurance during the highest consecutive 5 years in the 9-year period
8 years	26⅔% of your average amount of Life Insurance during the highest consecutive 5 years in the 8-year period
7 years	23⅓% of your average amount of Life Insurance during the highest consecutive 5 years in the 7-year period
6 years	20% of your average amount of Life Insurance during the highest consecutive 5 years in the 6-year period
5 years	16⅔% of your average amount of Life Insurance for the 5-year period
Less than 5 years	0

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* Applicable to employees returning on or after July 1, 1973.

** The ultimate amount of insurance for any period between 5 and 10 years will be prorated to the nearest month at the rate of 3⅓% per year. In determining the average amount of Life Insurance as specified above, each amount of Life Insurance used in the calculation shall not be less than the amount which reflects the highest normal straight-time annual earnings during the five years immediately preceding the date as of which such amount is computed.

ACCIDENTAL DEATH OR DISMEMBERMENT INSURANCE

(For Employees)

(Occupational and Non-Occupational)

In addition to any other benefits which you as a participating employee may receive, the benefits in the following table will be paid for bodily injury, either on or off the job, caused solely by accidental means and, independently of all other causes, resulting in death or loss of hand, foot, or sight of eye. These benefits will be based on your normal straight-time annual earnings at the date of the accident. However, if at the time of the accident the amount of your Accidental Death or Dismemberment Insurance is based [omission in original exhibit].

The minimum weekly benefit is $35 for anyone with normal straight-time annual earnings of at least $3000.

Benefits will start with the eighth day you are totally disabled (or with the first day of your confinement in a hospital as a bed patient, if earlier) and will continue during your total disability up to a maximum period of 26 weeks for any one continuous period of disability or for successive periods of disability due to the same or related cause or causes.

If you are a salaried employee, benefits of $15 a week will be payable during any period of salary continuance commencing with the eighth day of total disability (or with the first day of confinement in a hospital as a bed patient, if earlier), and ending with the day upon which you shall have received, during the preceding 12 months' period, twenty days of salary continuance for personal illness or ending when such salary continuance shall earlier cease. Thereafter, if you are still disabled, the regular benefits described in the initial paragraphs of this section will become payable and will be paid during

the remainder of your total disability, but for not more than an additional period of 26 weeks.

If, after you return to work, you again become disabled (a) from the same cause following at least a 90 day period at work as determined by Company rules, or (b) from a different and unrelated cause, you again become eligible for full benefits.

Of course, to collect these benefits, you must be under the care of a physician for the treatment of your disability and your claim must be certified by a physician.

Benefit for Occupational Disabilities

You may be entitled to benefits under a Workers' Compensation or Occupational Disease Statute for occupational disabilities. However, if, during the period corresponding to that for which you would be paid Weekly Sickness and Accident benefits under this Plan if your disability were a non-occupational disability, the amount to which you are entitled under any Workers' Compensation or Occupational Disease Statute for time lost from work is less than the amount of benefits to which you would be entitled under this Plan for non-occupational disabilities, you will be paid the difference.

COMPREHENSIVE MEDICAL EXPENSE INSURANCE

(For Employees and Dependents)
(Non-Occupational)

COMPREHENSIVE MEDICAL EXPENSE INSURANCE provided by this Plan for participating employees and for any of their covered dependents pays benefits for medical expenses as described below to the extent that such expenses are (1) for the diagnosis, care or treatment of non-occupational illness or injury, (2) reasonable, necessary, and customary and (3) for services performed or prescribed by a physician or surgeon, in a

hospital, at home, or elsewhere, including physician's or surgeon's services for consultation and confirming medical opinions. Such expenses are called Covered Medical Expenses and are of three types—Type A-1, Type A-2, and Type B.

For each covered individual, the lifetime maximum amount of benefits payable with respect to all his Covered Medical Expenses—Types A-1, A-2, and B combined—including any expenses for which benefits were paid under any prior General Electric Insurance Plan, is $350,000 in total, subject to reinstatement as described on page 7.

For the purpose of Comprehensive Medical Expense Insurance, an expense is deemed to have been incurred on the date the service is received or rendered.

Maternity Benefits

Benefits under Comprehensive Medical Expense insurance will be payable for covered medical expenses incurred by a participating employees or a covered dependent in connection with pregnancy, resulting childbirth or complications in connection therewith on the same basis as for any other disability. Such benefits also will be payable for any pregnancy which commences while insurance on account of such person is in force under this Plan.

Benefits for Type A-1 Covered Medical Expenses

Benefits on account of the Type A-1 expenses described below will be payable, for 365 days in each calendar year, at 100% of such expenses, for any one employee or any one covered dependent subject to the lifetime maximum amount specified on page 5.

1. Expenses incurred for room and board accommodations up to an amount equal to the full semi-private room rate, in (i) a legally constituted hospital or (ii) a

licensed detoxification facility upon the recommendation and approval of a physician for the treatment of alcoholism or drug addiction. Private room charges will be considered Covered Medical Expenses to the extent of the hospital's or facility's most common semi-private room rate, except that if confinement in a private room accommodation is medically required because of a contagious disease, as certified by a physician, the full private room rate will be paid.

2. Special hospital and detoxification facility services required for medical or surgical care or treatment, such as operating room, drugs, dressings, blood transfusions (including blood or blood plasma), oxygen and administration thereof, received during a hospital confinement of at least 18 hours in a hospital or detoxification facility. However, if because of an accident, emergency care is received in a hospital not later than the day following the injury, or if an operation is performed in a hospital, benefits on account of these special hospital services are payable even if the period of confinement is less than 18 hours.

3. Expenses incurred for room and board and special services at an ambulatory surgical facility.

4. Effective January 1, 1980, expenses incurred for room and board, special services and drugs and medical supplies in an extended care facility during a confinement which:

a. is for convalescent care which requires medical supervision and skilled nursing services,

b. commences within 14 days after termination of a period of covered hospital confinement which continued for at least 3 days and is ordered by a physician as necessary for convalescence from an illness or injury, or treatment of a terminal condition or a long-term disability, and

c. is for the same or related cause or causes as such period of hospital confinement.

The following services are not Covered Medical Expenses:

(i) in the case of private room accommodations, any charges in excess of the facility's most common semi-private room rate, and

(ii) custodial care

The maximum period for which extended care facility charges are included as Covered Medical Expenses is 120 days for the same or related cause or causes.

5. Effective January 1, 1980, expenses incurred in connection with a home therapy program, accredited by the National Hemophiliac Foundation and approved by the Insurance Company, for the treatment of a hemophiliac, while under the care of a physician.

6. Effective January 1, 1980, expenses incurred in an approved hospice care program for treatment of a terminally ill covered individual whose life expectancy approximates 6 months or less. The program must be accredited by the National Hospice Organization and approved by the Insurance Company. Treatment must be rendered and billed by the hospice care program and may be provided either in the hospice facility or in the individual's home, and also may include family counseling.

7. Effective July 1, 1980, expenses incurred for services rendered by a home health care agency approved by the Insurance Company for the following services and supplies furnished to a covered individual in such person's home in accordance with a home health care program provided such home health care commences within seven days following termination of a period of covered hospital or extended care facility confinement as a registered bed patient, and is for the same cause or a cause related to that for which such individual was so confined:

a. nursing care by or under the supervision of a registered graduate nurse,

b. home health aide services which consist primarily of caring for the patient,

c. physical therapy, occupational therapy, and speech therapy provided through the home health care agency,

d. medical supplies, drugs and medications prescribed by a physician, and laboratory services, and

e. medical social services rendered by a qualified social worker under the supervision of a physician.

The following services and supplies are not covered medical expenses:

(i) services of a person who ordinarily resides in the employee's home or is a member of the employee's immediate family,

(ii) services and supplies not related to medical care and treatment,

(iii) services rendered in any period during which the employee or dependent is not under the continuing care of a physician, and

(iv) custodial care.

Benefits for Type A-2 Covered Medical Expenses

Benefits on account of the Type A-2 expenses described below will be payable, during any one calendar year, at 100% of the first $500 of such expenses and at 85% of any additional expenses, for any one employee or any one covered dependent subject to the lifetime maximum amount specified on page 5.

1. Anesthetics and administration thereof—in a hospital, at home, or elsewhere.

2. Surgery performed by surgeons and assistant surgeons in a hospital, at home, or elsewhere.

Effective July 1, 1980, if a physician or surgeon has recommended a non-emergency surgical procedure for which benefits under this Plan would be payable, benefits will also be payable for expenses incurred in connection

with a second surgical opinion and expenses for any diagnostic x-rays and laboratory procedures in connection with such opinion, provided the physician or surgeon examines the patient in person and submits a written report to the Insurance Company. Benefits on account of expenses incurred for such a second surgical opinion will not be considered in determining the amount of other benefits payable during any one calendar year. Until July 1, 1980, surgery also includes dental surgery for:

a. Removal of an impacted tooth

b. Removal of a tooth root without extraction of the entire tooth (Apicoectomy)

c. Other cutting procedures on the gums and tissues of the mouth when not performed in connection with extraction, repair or replacement of teeth.

d. Extraction, removal of tooth, uncomplicated—including local anesthesia.

e. Extraction—multiple removal of teeth—including local anesthesia.

f. Extraction—odontectomy, soft tissue—including local anesthesia.

g. Alveolectomies

h. Pulp Capping

i. Vital Pulpotomy

j. Root Canal Filling

k. Anterior tooth; root canal filling with root-end amalgam.

l. Gingival Curettage

If you are participating in this Plan on June 30, 1980 and have less than one year of continuous service on that date, coverage for the above dental surgical procedures will continue until the earlier of the date you become covered under the General Electric Dental Assistance Plan or the date your Company service is terminated as determined by Company rules.

3. Local professional ambulance service.

4. Diagnostic X-Rays (and effective January 1, 1980, diagnostic imaging procedures), in a hospital, at home, or elsewhere.

Benefits for Type B Covered Medical Expenses

Benefits are payable on account of the Type B expenses described below which, during any one calendar year, are in excess of an initial amount of $50 for any one employee or any one covered dependent. Benefits will be 85% of all such expenses in excess of $50, subject to the lifetime maximum amount specified on page 5.

1. Services of physicians, including specialists, in a hospital, at home, or elsewhere.

If any of the services for the diagnosis, care or treatment of nonoccupational illness or injury for which benefits are provided under this Plan when performed or prescribed by a physician or surgeon, are rendered by a psychologist (as defined in this Plan) while acting within the lawful scope of his practice, benefits for such service will be provided on the same basis as if the service had been rendered by a physician or surgeon.

2. Services of registered graduate nurses—other than a nurse who ordinarily resides in the employee's home or who is a member of the employee's immediate family.

3. The following expenses, unless such expenses qualify as Type A-1 or A-2 expenses.

a. Diagnostic laboratory procedures

b. X-ray and radium treatments

c. Oxygen and administration thereof

d. Blood transfusions, including blood or blood plasma

e. Drugs and medicines requiring a physician's prescription and dispensed by a licensed pharmacist.

4. Rental of iron lung or other durable equipment required for therapeutic use.

5. Artificial limbs or other prosthetic appliances, except replacements of such appliances.

6. Expenses for the purchase of a hearing aid and expenses for examinations and the fitting thereof, within the limitations of:

a. only one such purchase in any thirty-six month period and,

b. expenses up to $300 in connection with any one such purchase,

excluding however, the replacement and repair of any part or parts of such hearing aid following such purchase.

7. Effective January 1, 1980, services of a Christian Science practitioner—other than a Christian Science practitioner who ordinarily resides in the employee's home or who is a member of the employee's immediate family—for actual visits for healing purposes provided such practitioner is accredited by the Mother Church in Boston, Massachusetts at the time of such visits.

Other Provisions

Benefits are determined separately for each individual. However, with respect to Type B Covered Medical Expenses, (a) if two or more covered members of a family should incur Covered Medical Expenses as a result of the same accident, the $50 initial amount referred to above will be applied only once against such Expenses during the calendar year in which the accident occurs, regardless of the number of family members injured; (b) the total initial amount of Covered Medical Expenses for which no benefits are payable will not exceed $125 for any employee and all his covered dependents in a calendar year, including any carryover as described in the following paragraph.

If any part or all of the initial amount of your own expenses for a calendar year arises from Type B Covered Medical Expenses incurred during the last three months of that calendar year, then that portion of such initial amount will be used to reduce the initial amount for the next calendar year. This provision will also apply to each of your covered dependents.

For mental or nervous conditions, the Plan will pay the benefits described on page 6 except that for Covered Medical Expenses incurred on account of psychiatric treatments or consultations while an employee is not totally disabled so as to be prevented from working or while a covered dependent is not confined in a hospital or similar institution, the rate of benefit will be 50% instead of 85% for Type B expenses.

If at any time benefits of at least $1000 have been paid for Covered Medical Expenses of a participant or covered dependent and evidence of the complete recovery and insurability of the person on whose account such benefits were paid is submitted to the Insurance Company, the amount of such benefits paid will not be included in determining the $350,000 lifetime maximum amount of benefits on account of such person on and after the date the Insurance Company accepts as satisfactory such evidence of insurability.

Effective January 1, 1980, if, during a calendar year, the combined unreimbursed Covered Medical Expenses of a participating employee and covered family dependents exceed $1,000, the Plan will pay 100% of all Covered Medical Expenses incurred thereafter by such individuals for the balance of that calendar year. Unreimbursed Covered Medical Expenses consist of the calendar year deductibles and the coinsurance portion of the Covered Medical Expenses which are payable by you, but do not include Covered Medical Expenses in excess of the lifetime maximum amount of benefits of $350,000 per covered individual.

In the event a participating employee or covered dependent is entitled to receive payment or reimbursement from any other person or persons as a result of legal action or claim (except against insurers on policies of insurance issued to the participating employee in his name or to any family member who ordinarily resides in his household) with respect to any expenses paid or reimbursed to him under this Plan, the Insurance Company shall be entitled to rights of subrogation against such other person or persons.

Exclusions

Expenses for the following are not Covered Medical Expenses under the Plan:

a. Expenses incurred by or on account of an individual prior to the effective date of the Plan as to him.

b. Expenses for dental services and appliances of any kind except expenses for hospital room and board and other special hospital services while a bed patient in connection with dental treatment. However, until July 1, 1980, (1) expenses for dental services and appliances required for correction of damage caused by accidental injury while insured, and (2) expenses for dental surgery to the extent provided on page 6 shall not be excluded provided such expenses otherwise qualify as Covered Medical Expenses. In the event you are participating in the Plan on June 30, 1980 and have less than one year of continuous service, coverage for the dental expenses in (1) and (2) above will continue until the earlier of the date you become covered under the General Electric Dental Assistance Plan, or the date your Company service is terminated as determined by Company rules.

c. Eye glasses, hearing aids and examinations for the prescription or fitting thereof. However, expenses for the purchase of a hearing aid and expenses for examinations and the fitting thereof shall not be excluded to the extent specified under Covered Medical Expenses.

d. Medical examinations or laboratory tests for check-up when not incident to treatment of injury or sickness.

e. Cosmetic surgery or treatment except to the extent necessary for correction of damage caused by accidental injury while insured.

f. Any services received because of sickness or injury arising out of or in the course of employment and entitling the employee or dependent to benefits under a Workers Compensation or Occupational Disease Law.

g. Services received in a hospital owned or operated by the United States Government, unless and to the extent that such hospital is specifically excepted from the limitations of this paragraph (g) by the Insurance Company on the ground that such hospital is the sole or virtually the sole source of hospital service for a community.

h. Services received for sickness or injury due to war (declared or undeclared) or any act of war, which act shall have occurred after the effective date of this Plan.

i. Expenses for which the individual is not required to make payment.

j. Expenses for which payment or reimbursement is received by or for the account of the individual as the result of a legal action or settlement (other than from a policy of insurance issued to the participating employee in his name or to any family member who ordinarily resides in his household).

k. Expenses to the extent of benefits provided under any employer group plan other than this Plan, except for any such employer group plan for which those insured under that plan are required to pay the full premium cost or subscription fee; also, expenses to the extent of benefits paid, or for which a covered individual is eligible to have paid upon proper application thereof under the Health Insurance for the Aged Act of the United States (Medicare).

However, the foregoing Exclusion (k) will be disregarded to the extent necessary to provide that, for all medical expenses incurred in a calendar year on account of the person for whom claim is made, the aggregate of the Comprehensive Medical Expense benefits payable under this Plan, together with the benefits payable or available (or the reasonable cash value of services rendered) under such other plan or plans, will equal the total amount of such medical expenses which are covered under any of the plans. Of course, the benefits under this Plan may not exceed those which would have been payable in the absence of the foregoing Exclusion (k).

In addition, the person claiming benefits shall furnish to the Insurance Company such information as may be necessary for the purposes of administering this provision.

l. Expenses to the extent paid, or which a covered individual is eligible to have paid upon proper application therefor, either directly or indirectly, under any other law, plan or program of any government, or any political subdivision thereof, of any country which provides medical care benefits, or under any plan, policy or contract, other than this Plan, if the cost thereof shall have been paid in whole or in part, either directly or indirectly, by the Company as the result of any such law, plan or program.

Covered Medical Expense Benefits after
Retirement or Attainment of Age 65

1. If you Continue to Work Beyond Your 65th Birthday

If you continue in Company employment beyond the end of the month in which you reach age 65, Comprehensive Medical Expense Insurance for yourself and your covered dependents will be continued until the date your service with the Company is terminated, provided you pay any required contributions.

The Company will reimburse you for the premium you pay for Medicare Part B for yourself provided you are enrolled for Medicare Part A and Part B. The first premium reimbursed will be that for the month in which you become eligible for and enroll for Medicare Part B and such reimbursement will be made only for the months during which coverage remains in force for you under this Plan and you continue to be enrolled for Medicare Part A and Part B .

On the date your service with the Company terminates, all Comprehensive Medical Expense Insurance for yourself and for your covered dependents will be discontinued except as provided in this and in the following paragraphs. If at that time, you or one or more of your covered dependents is totally disabled, Covered Medical Expense benefits will be continued as described on page 10 under "Special Provisions Applicable upon Discontinuance of Comprehensive Medical Expense Insurance.

If coverage for one or more of your dependents was not extended as provided in the preceding paragraph, and at the end of the month in which you retired from the Company on pension, you had (1) at least ten years of continuous service with the Company and (ii) been insured for Comprehensive Medical Expense Insurance under this Plan for as long as you were eligible during the 10-year period immediately prior to the end of the month in which you retired, you may elect to continue Comprehensive Medical Expense Insurance for your covered dependents, subject to the payment of the required contributions until:

a. with respect to insurance on account of dependent children, the date such person ceases to be a dependent, and

b. with respect to insurance on account of your spouse, the earlier of (i) the date your spouse becomes eligible for coverage under the Health Insurance for the Aged

Act of the United States (Medicare), because of age, or (ii) the date of your spouse's remarriage in case of your death.

Such insurance will then be discontinued except as provided in this and in the following paragraphs. If at that time one or more of your covered dependents are totally disabled, Covered Medical Expense benefits will be continued as described on page 10 under "Special Provisions Applicable upon Discontinuance of Comprehensive Medical Expense Insurance".

If you retire from the Company on pension, have at least ten years of continuous service with the Company which includes service after you reach age 65, and have been insured for Comprehensive Medical Expense Insurance under this Plan for as long as you were eligible during the 10-year period immediately prior to the end of the month in which you retire, insurance for medical expense will be provided under the Medical Care Plan for Pensioners (described below) for you (unless covered under this Plan) and your spouse (unless covered under this Plan or the Medical Care Plan for Pensioners on his/her own account) following the date of your retirement. In case either you or your covered dependent spouse is totally disabled when you retire, the benefits for you or your spouse specified in the paragraphs entitled "Medical Care Plan for Pensioners" will, for such disabled individual, become effective when the benefits provided under this Plan cease to apply.

2. If You Retire On or Prior to Your 65th Birthday

If you retire from the Company on pension prior to age 65, or if you leave the service of the Company after you are entitled to optional retirement under the Company's Pension Plan, or if you leave on a retirement allowance granted by the Company, Comprehensive Medical Expense Insurance for yourself and for your covered dependents will be continued until the end of the month in

which you reach age 65, provided you pay any required contributions.

At the end of the month in which you reach age 65, all Comprehensive Medical Expense Insurance for yourself and for your covered dependents will be discontinued except as provided in this and in the following paragraphs. If at that time, you or one or more of your covered dependents are totally disabled, Covered Medical Expense benefits will be continued as described on page 10 under "Special Provisions Applicable upon Discontinuance of Comprehensive Medical Expense Insurance".

If coverage for one or more of your dependents was not extended as provided in the preceding paragraph, and at the end of the month in which you reach age 65, you retired from the Company on pension and had (i) at least ten years of continuous service with the Company and (ii) been insured for Comprehensive Medical Expense Insurance under this Plan for as long as you were eligible during the 10-year period immediately prior to the end of the month in which you reach age 65, you may elect to continue Comprehensive Medical Expense Insurance for your covered dependents, subject to the payment of the required contributions until:

a. with respect to insurance on account of dependent children, the date such person ceases to be a dependent, and

b. with respect to insurance on account of your spouse, the earlier of (i) the date your spouse becomes eligible for coverage under the Health Insurance for the Aged Act of the United States (Medicare), because of age, or (ii) the date of your spouse's remarriage in case of your death.

Such insurance will then be discontinued except as provided in this and in the following paragraphs. If at that time one or more of your covered dependents are totally disabled, Covered Medical Expense benefits will be con-

tinued as described on page 10 under "Special Provisions Applicable upon Discontinuance of Comprehensive Medical Expense Insurance".

If you retire from the Company on pension and have at least ten years of continuous service with the Company and have been insured for Comprehensive Medical Expense Insurance under this Plan for as long as you were eligible during the 10-year period immediately prior to the end of the month in which you reach age 65, insurance for medical expenses will be provided under the Medical Care Plan for Pensioners (described below) for you (unless covered under this Plan) and your spouse (unless covered under this Plan or the Medical Care Plan for Pensioners on his/her own account) on the day following the end of the month in which you reach age 65. In case either you or your covered dependent spouse are totally disabled when you reach age 65, the benefits for you or your spouse specified in the paragraphs entitled "medical Care Plan for Pensioners" will, for such disabled individual, become effective when the benefits provided under this Plan cease to apply.

Medical Care Plan for Pensioners

The following benefits will be payable for you and your spouse subject to the maximum amount specified on page 8:

1. For Hospital confinements

a. $40 ($80, effective January 1, 1980) for the first day of confinement for which benefits are provided by Medicare (or would have been provided had the deductible been satisfied) and

b. $10 for each subsequent day of confinement for which benefits are provided by Medicare (or would have been provided had the deductible been satisfied) and

c. $40 for each day of confinement which extends beyond the 150 day period or such longer period for which

benefits are provided by Medicare, unless confined in a tuberculosis or psychiatric institution owned or operated by any government or agency thereof in which case the benefits in 2 below will be payable.

2. If confined in a tuberculosis or psychiatric institution owned or operated by any government or agency thereof or a portion of an extended care facility which qualifies for benefits under Medicare, $10 will be paid for each day of confinement which extends beyond the period for which benefits are provided by Medicare.

3. If not eligible for benefits under Medicare because of residence or travel outside of the United States or its possessions, or because of age, benefits are payable on account of Type A-1 or A-2 Covered Medical Expenses as described on page 6 (including the dental surgical procedures in effect on July 1, 1979) which, during any one calendar year, are in excess of an initial amount of $25 for you or for your spouse. Benefits will be 100% of the next $225 of such expenses and 85% of any additional expenses, subject to the maximum amount specified below.

The total amount of benefits payable for medical expenses on account of you and your spouse during the remainder of your lifetime after the end of the month in which you reach age 65 or the date of your retirement if you work beyond age 65 (or the later date described above with respect to total disability), whether for one cause or different causes will be limited to a total of $11,000 ($21,000, effective July 1, 1979) subject to the following provisions.

The first $10,000 ($20,000, effective July 1, 1979) of benefits will be payable by the Trustees of the General Electric Medical Care Trust for Pensioners (or in such other manner as may be elected by the Company). The remainder of the benefits will be paid under this Insurance Plan and, as such benefits are paid, a corresponding

reduction will be made in the ultimate amount payable under the Plan upon death, as described on page 4.

Furthermore, in the event of your death, your surviving spouse will have medical care benefits available equal to the remaining balance, if any, of the amount of such benefits available to you after the end of the month in which you reach age 65 or the date of your retirement, if you work beyond age 65, except for that part of the remaining benefit payment which would have reduced the amount of your Life Insurance.

If at the end of the month in which you reach age 65 or the date of your retirement, if you work beyond age 65, you have less than ten years of continuous service or are otherwise ineligible for the Medical Care Plan for Pensioners benefits described above, you may apply to the Insurance Company for an individual policy of Hospital Expense and Surgical Operation Insurance or similar type of policy then being issued for conversion purposes by the Insurance Company for yourself or, if at that time you had insurance for your dependents under the Plan, you may apply for Hospital Expense and Surgical Operation Insurance or similar type of policy then being issued for conversion purposes by the Insurance Company for yourself and your dependents, as described on page 10.

PENSIONERS PRESCRIPTION DRUG PLAN

If you are covered by the Medical Care Plan for Pensioners, effective January 1, 1980, you will be covered by the General Electric Pensioners Prescription Drug Plan which provides benefits for prescription drugs and medicines. Your spouse, unless covered under the General Electric Insurance Plan or the Medical Care Plan for Pensioners on his/her own account, will also be covered under the General Electric Pensioners Prescription Drug Plan when you become covered, if your spouse is age 65 or older on such date, otherwise, on the first of the month following your spouse's attainment of age 65. Coverage

of your surviving spouse, in the event of your death, will continue or will begin on the first of the month following your surviving spouse's attainment of age 65, if later. The benefits provided under the General Electric Pensioners Prescription Drug Plan will not be taken into account in connection with the lifetime limit of benefits under the Medical Care Plan for Pensioners for you and your spouse.

YOUR CONTRIBUTIONS FOR THE INSURANCE PLAN

Your contributions upon your enrollment for participation in the Plan will be as follows:

1. No contributions will be required for the full benefits of this Plan with respect to your employee coverage.

2. If you enroll for Comprehensive Medical Expense Insurance with respect to your dependents your contributions will be 2% of your normal straight-time annual earnings up to $5,000 of such earnings, a maximum contribution of $100 per year.

Any required contributions with respect to insurance on behalf of your dependents will be made by means of periodic payroll deductions from regular payments of compensation by the Company to you. If, on or after the date on which this Plan becomes effective as to you, you are laid off after you have three years of continuous service with the Company, you become totally disabled, or you begin an absence because of pregnancy, your contributions for dependent coverage will be waived as described on page 9. In the event you are laid off before you have three years of continuous service with the Company or are granted a leave of absence, contributions for your dependent coverage in an amount equal to the foregoing percentages of your normal straight-time annual earnings at the time of layoff or leave of absence, as the case may be, must be paid in monthly installments

in advance to the Company in order that your dependent coverage will be continued during such period.

If your normal straight-time annual earnings change any required contributions for dependents coverage under the Plan will increase or decrease in accordance with such change effective on the date such change is made if you are then actively at work or, if not, on the date you return to active work.

If you retire from the Company on Pension prior to age 65, or if you leave the service of the Company after you are entitled to optional retirement under the Company's Pension Plan, or if you leave on a retirement allowance granted by the Company, to keep your dependent coverage in force you will be required to continue your contribution for such coverage until you reach age 65, at the contribution rate in effect immediately prior to retirement, or to leaving the service of the Company.

The Company will pay the difference between the net cost of the Plan and the amount contributed by participating employees.

GENERAL PROVISIONS

Eligibility and Effective Date

All employees as defined on page 13 are eligible to participate in the Plan except (a) employees hired on a temporary basis, (b) individuals on retainer, and (c) other special classes of employees as prescribed by the rules of the Company from time to time.

If you are eligible to participate in the Plan, you will be covered under this Plan from your first day of actual work. An enrollment card for employee coverage should be completed so you may designate your beneficiary under the Life Insurance portion of the Plan.

You also may enroll for Comprehensive Medical Expense Insurance with respect to your eligible dependents.

Insurance for your dependents, if you enroll for that insurance, will become effective on the date you enroll but not before you become insured yourself as a participating employee. However, if on the effective date of the insurance for your dependents, a dependent is confined in a hospital or other institution for care or treatment or is confined at home under the care of a physician or surgeon because of a disabling physical or mental sickness or injury, coverage for that dependent shall not be effective until he or she has been discharged from the hospital or other institution, and is no longer confined at home under the care of a physician or surgeon.

Confinement of a newborn child will not postpone coverage for such child provided you are enrolled for insurance for your dependents at the time of the child's birth.

In the event that both you and your spouse are employed by the Company only one of you may enroll for dependent coverage on account of your child or children.

No Medical Examination

No medical examination for your dependents is necessary if you enroll on or before the date when you could first become insured with respect to your dependents or within thirty-one days thereafter.

If you do not enroll for insurance with respect to your dependents within thirty-one days of the date you first become eligible for such insurance or if such insurance ceases because you request cancellation of such coverage and you subsequently request reinstatement of such insurance, the Insurance Company may require that you provide satisfactory evidence of good health for each of your dependents at your own expense before you may become insured for such insurance. In such event, the coverage on account of each such dependent shall become effective on the date the Insurance Company accepts as satisfactory such evidence of good health of that dependent.

However, satisfactory evidence of good health of a dependent will not be required if you submit evidence which shows that the application for such dependent is being made within 31 days following the termination of medical expense coverage for that dependent under another employer group plan or under the General Electric Insurance Plan.

If both you and your spouse are employed by the Company, the thirty-one day period during which satisfactory evidence of good health for dependent coverage is not required begins on the earliest date either you or your spouse becomes eligible to enroll for dependent coverage.

Coverage for eligible dependents will be provided only by proper enrollment for such coverage, as described in the provisions set forth on pages 8 and 9.

Changes in Amounts of Insurance

If your normal straight-time annual earnings change so as to make you eligible for a different amount of insurance, your insurance under the Plan will increase or decrease in accordance with such change effective on the date such change is made if you are then actively at work or on paid vacation, if not, on the date of your return to active work.

Provisions Applicable If You Are Absent from Work

1. Total Disability

If you become totally disabled or if you cease work because of pregnancy on or after the date on which this Plan becomes effective as to you, your insurance, other than Weekly Sickness and Accident Insurance, will remain in force during a period of total disability of one week or more, up to a maximum period of one year (18 months in the case of occupational disabilities), but only as long as your continuity of service with the Company

is maintained, as determined by the Company's rules, subject to periodic proof of continuance of such disability. Insurance for your dependents will also continue in force under the conditions referred to in the preceding sentence, without further payment of contributions.

Weekly Sickness and Accident Insurance will be discontinued on the date you cease active work because of total disability or pregnancy, except that if you are entitled to Weekly Benefits for a disability existing on such date of cessation, Weekly Sickness and Accident Insurance will be continued until the expiration of the maximum period for which such benefits are payable for such disability in accordance with the provisions of the Plan. Such Insurance may be reinstated only upon your return to active work.

At the end of the maximum period referred to in the second preceding paragraph above or the termination of your continuity of service, whichever is earlier, all of the insurance provided by this Plan will cease, except as provided in this paragraph and on page 10. If before age 60 and while insured under the Plan, you had become totally disabled which, for the purposes of this paragraph only, means total disability as a result of bodily injury or disease so as to be wholly prevented thereby from engaging in any and every business or occupation and from performing any work for compensation or profit, your Life Insurance protection will be continued for the full amount until you reach age 65 provided you furnish proof satisfactory to the Insurance Company of the continuance of such total disability at least once each year. Commencing at age 65 the Life Insurance will be reduced gradually as provided on page 4.

2. Layoff or Leave of Absence

If you should be laid off or are granted a leave of absence (other than for military duty) on or after the date on which this Plan becomes effective as to you, your in-

surance, except for Weekly Sickness and Accident Insurance, will be continued up to a minimum period of one year, in the case of layoff or for the duration of your leave, but only as long as your continuity of service is maintained as determined by the Company's rules.

If you should be laid off after you have completed three or more years of continuous service with the Company (at the time of layoff) insurance for your covered dependents will be continued without payment of contributions (in layoffs of one week or more) up to a maximum period of one year, but only so long as your continuity of service is maintained as determined by Company rules.

If you should be laid off before you have three years of continuous service with the Company or if you are granted a leave of absence (other than for military duty), you may, upon payment of your regular contributions monthly in advance, continue insurance for your covered dependents, up to a maximum period of one year in the case of layoff but only as long as your continuity of service is maintained as determined by the Company's rules or for the duration of your leave of absence in case you are granted such a leave.

Benefits with respect to your Weekly Sickness and Accident Insurance will not be payable for any period of disability which begins more than 31 days after such layoff or leave of absence commences.

If insurance with respect to your dependents was discontinued during a period of layoff or leave of absence because of failure to make any required contributions for your dependent insurance, such coverage may be reinstated only upon your return to active work in accordance with the provisions under the caption "Eligibility and Effective Date."

If you leave for military duty, provision may be made with the Company for the continuation of the Life Insurance provided by this Plan for a limited period. Notice will be given from time to time of the Company's practice as to the continuation of insurance for dependents of employees who leave for military duty.

3. Strike

If you cease work because of a strike, your insurance coverage and insurance for your covered dependents automatically will terminate on the day immediately preceding the first full day's absence from active work because of the strike. However, the Company may, in its discretion, make appropriate arrangements to continue your coverage under this Plan during such strike.

In any event, Weekly Sickness and Accident Insurance will not be continued beyond 31 days from the date last worked and will not be reinstated until you return to active work.

Retirement

Upon retirement on pension or otherwise, all of your insurance hereunder will be discontinued except to the extent that your Life Insurance and Comprehensive Medical Expense Insurance may be continued under the provisions beginning on pages 4 and 7. Individuals who leave the employ of the Company with vested rights under its Pension Plan are considered to have terminated employment rather than to have retired.

Group Practice Option

If you are enrolled for Comprehensive Medical Expense Insurance for yourself and any covered dependents and elect to receive medical care under a local group practice plan in lieu of Comprehensive Medical Expense Insurance provided by this Plan, you will receive a supplement outlining the effect on your coverage under this Plan and information concerning the financial arrangements.

Termination of Employment or Failure to Make Contributions

If your employment with the Company is terminated other than by retirement, and continuity of service, as determined by the Company's rules, is lost for any reason whatsoever, all insurance under the Plan will automatically cease on the date of such termination.

If you fail to make any required contributions when due, all insurance under the Plan for which contributions are required will automatically cease at the end of the period for which contributions have been paid.

In the event your employment terminated because of a plant closing, your employee coverage (except Weekly Sickness and Accident Insurance) and coverage for your dependents will be continued for one year beyond the date of the plant closing or your termination date if later except that if you have less than 3 years of continuous service at the date of plant closing your dependent insurance will be continued only if you make the required contributions monthly in advance. At the end of such period, the conversion privileges as described below will be available for 31 days after cessation of insurance. With respect to Weekly Sickness and Accident Insurance, benefits will not be payable for any period of disability which begins more than 31 days after your last day of work.

Special Provisions Applicable upon Discontinuance of Comprehensive Medical Expense Insurance

If you or one or more of your dependents are totally disabled when Comprehensive Medical Expense Insurance is discontinued, benefits are payable for that individual in accordance with the provisions of the Plan during the continuance of total disability, but not beyond the end of the calendar year following the calendar year in which such Insurance is discontinued.

During any period when, because of your total disability, benefits are provided for you pursuant to the preceding paragraph, Comprehensive Medical Expense benefits will also be provided for your dependents on whose account you were insured on the date your insurance was discontinued, and further provided that such dependents would otherwise continue to qualify as eligible dependents under this Plan.

When your benefits cease, either because of recovery or the expiration of the period specified in the preceding paragraphs, you may apply for a converted policy, as described on page 10, provided that application for such policy is made within 31 days after the date your benefits cease.

Life Insurance Conversion Privilege

Upon termination of your service with the Company they may arrange with the Insurance Company to continue you Life Insurance under an individual policy, without medical examination, if you make written application for it within 31 days after Life Insurance under the Plan ceases. The individual Life Insurance policy will be issued upon and one of the forms of policy then customarily issued to the Insurance Company (except Term Insurance and except policies containing provisions for Disability or Accidents Dealth Benefits), at the rate applicable to your class of risk and age at that time. However, at your opinion, such indidividual policy may be preceded by single premium term insurance for a period of one year. The amount of such individual policy will be equal to (or at your option less than) the amount of your Life Insurance in effect upon the date of your termination of service. Such individual policy will be effective at the end of the 31-day period, but if you should die during this period, the amount of your Life Insurance under the Plan will be payable to your beneficiary.

If your Life Insurance protection has been continued because of Total Disability (as described on page 9), the Life Insurance conversion privilege described above will

be available to you on the date you cease to be so totally disabled, provided you do not return to active work with the Company.

If an individual policy of Life Insurance has been issued pursuant to the foregoing paragraph, payment of any Life Insurance under this Plan will be made only if such individual policy is surrendered to the Insurance Company without claim. In such case, any premiums paid on such individual policy shall be refunded by the Insurance Company.

Health Insurance Conversion Privilege

If at the time of termination of your service with the Company, for any reason whatsoever, you are covered for Comprehensive Medical Expense Insurance under the Plan, you may arrange to obtain from the Insurance Company, without furnishing evidence of insurability, an individual policy for yourself or, if at that time you had insurance for your dependents under this Plan, an individual policy for yourself and such dependents, providing Hospital Expense Insurance or Hospital Expense and Surgical Operation Insurance or a similar type of policy then being issued for conversion purposes by the Insurance Company. The converted policy, which will include the provisions applicable to such forms of policy then being issued by the Insurance Company, may be obtained by making application to and paying the required premium to the Insurance Company within 31 days after cessation of your Comprehensive Medical Expense Insurance.

Your dependents may apply for conversion of their coverage if they do so within 31 days after their coverage if terminated unless such termination was at your request.

You or your dependents may obtain information concerning the individual policies currently available, and the applicable premium rates, as well as the proper application form from your employee relations or personnel accounting office. (See reverse side of your certificate.)

Dependent Coverage after Employee's Death

If you should die while Comprehensive Medical Expense Insurance is in effect as to your covered dependents, such insurance will be continued in effect, without payment to contributions, for all covered eligible dependents for period of one year following the date of your death. At that time the Health Insurance Conversion Privilege described in the preceding paragraphs will be applicable to your covered dependents.

Payments of Benefits

Benefits for Type A-1 Covered Medical Expenses under the Plan are provided through Blue Cross of Massachusetts, Inc. Weekly Sickness and Accident Insurance benefits and Type A-2 and B Covered Medical Expenses are primarily payable from the General Electric Insurance Plan Trust, except that for California employees such benefits (as set forth in the applicable insert) and Expenses are provided by the Company and Aetna Life Insurance Company, respectively. Medical expense benefits after age 65 are provided as stated on pages 7 and 8 through the General Electric Medical Care Plan for Pensioners. Metropolitan Life Insurance Company is liable for all Life Insurance and Accidental Death or Dismemberment Insurance benefits under the Plan except that Puritan Life Insurance Company is liable for Life Insurance and Accidental Death Insurance benefits for employees of General Electric Credit Corporation and its affiliates, and the General Electric Insurance Plan Trust is liable for payment of Trust Death Benefits up to the first $5,000 of the ultimate amount for pensioners who die after reaching age 70, as described on page 4. Metropolitan Life Insurance Company also is liable for all Weekly Sickness and Accident Insurance and Comprehen-

sive Medical Expense Insurance benefits (other than Type A-1 Covered Medical Expenses and, for California employees, Weekly Sickness and Accident Insurance and Type A-2 and B Covered Medical Expenses) which are not payable from the General Electric Insurance Plan Trust.

Determinations of all benefit payments under the Plan will be made by Blue Cross of Massachusetts, Inc for Type A-1 Covered Medical Expenses, by Aetna Life Insurance Company for Type A-2 and B Covered Medical Expenses for California employees, by the Company for Weekly Sickness and Accident Insurance benefits for California employees, by Puritan Life Insurance Company for Life Insurance and Accidental Death Insurance benefits for employees of General Electric Credit Corporation and its affiliates and by Metropolitan Life Insurance Company for all other benefit payments.

Accordingly, the management and control of the operation and administration of claim procedures under the Plan, including the review and payment or denial of claims and the provision of full and fair review of claim denial pursuant to Section 503 of the Act, shall be vested in Blue Cross of Massachusetts, Inc., Aetna Life Insurance Company, the Company, Puritan Life Insurance Company, and Metropolitan Life Insurance Company, severally, with respect to that portion of the Plan for which each such entity determines benefits.

Claims for Benefits

Benefits under the Plan are payable upon receipt of proof of claim.

You should file claims promptly through such office as may be designated locally, such as your personnel accounting or employee relations office, for any benefits to which you may be entitled under the Plan upon forms which may be obtained locally. However, you are not required to submit claim forms for Type A-1 Covered Medical Ex-

penses. Proof of claim must be filed not later than 90 days (effective January 1, 1980, 180 days) after the end of the calendar year in which the loss for which claim is made is incurred unless it is not reasonably possible to do so and proof is filed as soon as is reasonably possible. The Insurance Company and General Electric Company, with respect to the benefits determined by them, reserve the right to medically examine an individual for whom claim is made.

Benefits for all Covered Medical Expenses billed by a hospital will be paid directly to the hospital. However, if at the time proof of claim is filed, evidence is submitted that such expenses have been paid, in whole or in part, the applicable benefit will be paid to you.

You Will Receive a Certificate

If required by law you will receive an individual certificate issued by the applicable Insurance Company to evidence the insurance benefits granted you as a participant under this Plan.

Amendment or Termination

This Plan may be amended, suspended, or terminated by the Board of Directors, in whole or in part, at any time without limitation, except as may be otherwise provided in collective bargaining agreements and except further that no such amendment, suspension, or termination shall adversely affect to a material degree any benefit payable with respect to any sickness, injury, or expense incurred prior to the effective date of such amendment, suspension, or termination, or affect the amount of life insurance and/or Trust Death Benefits for those employee who have retired, as described on page 4.

Federal or State Legislation Affecting the Benefits of this Plan

Some jurisdictions have laws with provisions for certain disability benefits.

If any such law is amended, or if any other legislation should be enacted which provides or requires benefits similar to those described in this booklet, appropriate modification will be made in the provisions of the Plan for individuals affected by such legislation.

Management and Control of Assets of Trust and Liability for Benefits

To provide benefits (the "Trust Benefits") for Life Insurance, Accidental Death or Dismemberment Insurance, Weekly Sickness and Accident Insurance (other than for California employees), Comprehensive Medical Expense Insurance and Trust Death Benefits as described on page 4 the Company has created the General Electric Insurance Plan Trust Said Trust, which is an irrevocable trust, is for the purposes of (a) receiving such sums of money for the funding of the payment of Trust Benefits as may from time to time be paid or delivered to the "Trustees by the Company and by employees or transferred to the Trustees by the Insurance Company, and investing and reinvesting the same, (b) entering into one or more insurance contracts with the insurance Company with respect to the Trust Benefits, and (c) making, or providing for payment of the Trust Benefits.

The Company will advance funds during each month, on behalf of the Trust, to pay Trust Benefits in accordance with the Plan and the directions and guidelines of, and the provisions of the policy or policies of insurance issued to the Trust by, the Insurance Company. In addition, before the end of each month, the Company will pay to the Trust the estimated amount required for insurance

premiums relating to the Trust Benefits for that month. Within 90 days after the end of each month for which such advances and payments were made, the Company shall pay to the Trust the aggregate of employee contributions and Company contributions (including contributions for insurance premiums), with respect to Trust Benefits, actually required for such month, and the Trust shall reimburse the Company for the advances made by the Company during such month.

The Trust Agreement provides, among other things:

a. that the Board of Directors has the power to amend or terminate the Plan and the Insurance Plan Trust at any time, in accordance with the provisions of the Plan and the Trust Agreement;

b. that the Committee has the power to appoint individual trustees, or to provide for a single corporate trustee or a corporate co-trustee, who shall have the sole and exclusive authority and discretion (except as otherwise expressly provided herein and in the Trust Agreement with respect to the power and authority of the Committee and the appointment of one or more investment managers) to manage and control the assets of the Trust; and

c. that the Trustees or Trustee may (i) make investments of any character, to the extent allowed by applicable law including investments in the securities, obligations or open accounts of the Company, (ii) enter into one or more insurance contracts with the Insurance Company, with respect to the Trust Benefits, (iii) if there are two or more Trustees, allocate among themselves, both singly and to one or more committees, each consisting of two or more Trustees, their powers, duties, obligations and responsibilities relating to management and control of the assets of the Trust, and (iv) appoint and discharge an investment manager or managers, as defined in the Act, to manage and control the assets of the Trust.

The Committee shall have the authority to direct the Trustees, both generally and specifically, with respect to

the management and control of the assets of the Trusts and may appoint and discharge one or more investment managers, as defined in the Act, with authority to manage and control the assets of the Trust. Except to the extent that the Committee shall have given directions to the Trustees or an investment manager or managers shall have been appointed to manage and control the assets of the Trust, the Trustees shall continue to have sole and exclusive authority and discretion to manage and control the assets of the Trust together with all of the obligations and responsibilities attendant upon such authority and discretion.

Administration

For purposes of the Act, General Electric Company shall be the Administrator of the Plan.

Any Named Fiduciary and any fiduciary designated by a Named Fiduciary may use, employ, discharge or consult with one or more individuals, corporations or other entities with respect to advice regarding any responsibility, obligation or duty of such fiduciary in connection with the Plan. Named Fiduciaries with respect to this Plan may allocate fiduciary responsibilities among themselves by written instrument signed in the same manner as provided for delegations in the next succeeding paragraph, and a written record shall be kept thereof.

Any Named Fiduciary may designate other individuals, corporations or other entities, who are not Named Fiduciaries, to carry out such Named Fiduciary's responsibilities, obligations and duties with respect to the Plan, except to the extent the Act prohibits delegation of authority and discretion to manage and control the assets of the Plan. Such delegations may be revoked or modified at any time and any such delegation, revocation or modification shall be made by written instruments signed by the Named Fiduciary, if an individual, or, in the case of other entities who are Named Fiduciaries, in accordance with

the procedures governing the functions of such entity, and a written record shall be kept thereof.

Any individual, corporation or other entity may serve in more than one fiduciary capacity with respect to the Plan.

No liability shall attach to or be incurred by the members of the Committee, the Trustees, or the stockholders, officers, directors or employees of the Company, in whatever capacity, under or by reason of the terms, conditions or agreements contained in the Plan, the Trust Agreement or any law, rule or regulation, or for acts or decisions taken or omitted by any of them thereunder. The fiduciary responsibilities of the Named Fiduciaries shall be exercisable severally and not jointly, and each Named Fiduciary's powers, duties, obligations and responsibilities shall be limited to those specifically allocated to such fiduciary by or in accordance with the terms of the Plan. Without limiting the generality of the foregoing, members of the Committee shall not be liable for any act or action, whether of commission or omission, of any Trustee or investment manager. Further, in the event of any delegation in accordance with the Plan, no fiduciary shall be liable for any act or action, whether of commission or omission, taken by the person to whom the delegation is made. The provisions of this Paragraph shall be subject to the mandatory requirements of the Act.

DEFINITIONS

1. "Dependent"

The term "dependent" means (1) an employee's spouse and (2) any unmarried child under 23 years of age of an employee provided, however, that if the child is 19 years of age or over, the child is not employed full time and is principally dependent upon the employee for maintenance and support.

A child, wife or husband will not be considered a dependent if he or she either (a) is insured for medical expense benefits under any group plan of the Company, except as provided in the following sentence, (b) resides outside the United States and Canada, (c) is in the armed forces of any country, or (d) is required to submit evidence of good health and such evidence is not accepted as satisfactory by the Insurance Company. However, if an employee has retired, is age 65 or older, is no longer covered for Comprehensive Medical Expense Insurance and has a spouse who is employed by the Company, the spouse at work may cover the older spouse as a dependent.

The term "child" will mean (1) the employee's own children and legally adopted children, (2) step-children who reside in the employee's household, and (3) any other children supported solely by the employee and permanently residing in the household of which the employee is the head.

The age requirement for qualification as a dependent will be waived for a covered dependent child who, at attainment of age 23, is either:

a. A full-time student at school or college, or,

b. Incapable of self-sustaining employment for reason of mental illness or retardation or physical handicap. (Due proof of such incapacity shall be submitted by the employee to the Insurance Company whenever requested by the Insurance Company.)

Of course when any such child ceases to be a student, or if he recovers from his disability, coverage under this Plan for such child will automatically cease.

2. "Non-Occupational"

The term "non-occupational" means any sickness or injury not arising out of or in the course of employment and not entitling you or a covered dependent to benefits

under any Workers' Compensation or Occupational Disease Law.

3. "Physician" or "Surgeon"

The term "physician" or "surgeon" means a person legally licensed to practice medicine.

4. "Psychologist"

The term "Psychologist" means a person who meets one of the following qualifications:

(i) If practicing in a State or Province where statutory licensure or certification of psychologists exists, he holds a valid credential (as legally specified) for such practice;

(ii) If practicing in a State or Province where licensure or certification of psychologists does not exist, but where valid, nonstatutory (professional) certification is established by the jurisdiction's recognized psychological association, he holds such certification;

(iii) If practicing in a State or Province where neither statutory nor nonstatutory licensure or certification of psychologists exists, he holds a statement of qualification by a committee established for the purpose by the jurisdiction's recognized psychological association or, in the absence of such committee, he holds a diploma in the appropriate specialty awarded by the American Board of Examiners in Professional Psychology or its Canadian equivalent.

5. "Ambulatory Surgical Facility"

The term "ambulatory surgical facility" means a facility approved by the Insurance Company as meeting established criteria for handling surgical cases on a same day basis which would otherwise require hospital confinement.

6. "Extended Care Facility"

The term "extended care facility" means an institution which is primarily engaged in providing (a) skilled nursing care and related services for persons who require medical or nursing care, and (b) rehabilitation services for the rehabilitation of injured, disabled or sick persons, provided that such institution:

(i) is accredited by the Joint Commission on Accreditation of Hospitals as an extended care facility or is recognized under the Health Insurance for the Aged Act of the United States (Medicare) as an extended care facility; and

(ii) is not, other than incidentally, a place for rest, for domiciliary care, for the aged, for the blind, for the deaf, for the mentally deficient, or for persons suffering from tuberculosis, or a hotel or motel.

7. "Home Health Care Agency"

The term "home health care agency" means (a) a legally constituted hospital possessing a valid operating certificate issued in accordance with a public health law authorizing the hospital to provide home health care services, or (b) a home health care service agency possessing a valid certificate issued in accordance with a public health law, or similar legally valid credential, authorizing such organization or agency to provide home health care services.

The term "home health care program" means a program established and approved, including any modifications as later may be necessary, by a physician within seven days following termination of a period of covered hospital or extended care facility confinement as a registered bed patient, together with such physician's certification that the medical condition of the covered individual and the proper treatment of the specific condition would require continued confinement as a bed patient in a hospital or extended care facility in the absence of the services and

supplies provided as part of the home health care program.

8. "Group Practice Plan"

The term "group practice plan" means a health maintenance organization which under the Federal Health Maintenance Organization Act or under a similar state law which regulates health maintennace organizations is:

(i) certified as qualified to operate; and

(ii) required to be offered to eligible employees and their dependents.

9. "Company"

The term "Company" means General Electric Company and any affiliate.

10. "Board of Directors"

The term "Board of Directors" means the Board of Directors of General Electric Company.

11. "Affiliate"

The term "affiliate" means Electrical Mutual Liability Insurance Company and any corporation whose voting stock is owned in whole or in part, directly or indirectly, by General Electric Company.

12. "Employee"

The term "employee" means (a) any employee of General Electric Company or of any affiliate if such affiliate elects to participate in this Plan and if its participation is accepted by the Chief Executive Officer of General Electric Company or by such person or persons as he may designate, and (b) any employee of any affiliate who is designated for participation in this Plan, with approval

of the Insurance Company, by the Chief Executive Officer of General Electric Company or by such person or persons he may appoint.

13. "Insurance Company"

The term "Insurance Company" means Blue Cross of Massachusetts, Inc. with respect to Type A-1 Covered Medical Expenses, Puritan Life Insurance Company with respect to Life Insurance and Accidental Death Insurance for employees of General Electric Credit Corporation and its affiliates, Aetna Life Insurance Company with respect to Type A-2 and B Covered Medical Expenses for California employees, and Metropolitan Life Insurance Company with respect to all other benefit coverage under the Plan except Weekly Sickness and Accident Insurance benefits for California employees.

14. "Normal Straight-Time Annual Earnings"

Except as hereinafter provided in this paragraph, the term "normal straight-time annual earnings" means the amount which an employee is earning as salary or wages from the Company at the applicable time or was earning when last actively at work for the Company, extended to an annual basis, and shall include night shift bonus and cost of living adjustment. To such extent as the Pension Board may provide, the term "normal straight-time annual earnings" may include commissions, other variable compensation, and any special or supplemental payments; provided, however, that "normal straight-time annual earnings" shall not include payments for overtime (straight-time and premium). Where any inclusions in "normal straight-time annual earnings" are paid at times less frequent than an employee's regular payroll periods, the Pension Board may determine the compensation base to be used for both contributions and insurance benefits for periods prior to the determinations of the actual amounts of such inclusions. However, for purposes of

determining the highest amount of Life Insurance and Accidental Death or Dismemberment coverage during a preceding five year period, normal straight-time annual earnings used for such calculation will include commissions, other variable compensation, and any special or supplemental payments only to the extent expressly authorized by the Pension Board for such purposes.

In accordance with the foregoing definition, an employee's normal straight-time annual earnings shall be determined as follows:

1. In the case of

a. Hourly Rated Employees

52-1/6 times the employee's straight-time hourly wage times the number of hours in the employee's normal work week up to 40 hours per week.

An incentive worker's normal straight-time hourly wage shall be determined by the Company in accordance with its normal practices and shall be based upon the latest periodic earnings statistics where such statistics are available.

b. Salaried Employees

(i) Weekly rate—52-1/6 times the employee's regular weekly salary

(ii) Semi-monthly rate—24 times the employee's regular semi-monthly salary

(iii) Monthly rate—12 times the employee's regular monthly salary.

2. In other cases, in accordance with the Company's normal practices consistent with the above.

The Company's determination of an employee's normal straight-time annual earnings in accordance with the foregoing shall be final and conclusive and binding upon any person having any interest in this Plan.

15. "Normal Straight-Time Weekly Earnings"

An employee's normal straight-time weekly earnings shall be determined by dividing his normal straight-time annual earnings by 52-1/6.

16. "Company rules" or "Company practices"

Where reference is made in this Plan to Company rules or practices, such rules or practices shall be those in general effect in the Company and in the case of an employee covered by a collective bargaining agreement shall conform to any applicable provision of such agreement.

17. "Committee"

"Committee" means the Committee as defined in the General Electric Pension Plan.

18. "Named Fiduciary"

The term "Named Fiduciary" means any fiduciary with respect to the Plan who is either named in the Plan or who is appointed by the Company in writing.

19. "Fiduciary"

"Fiduciary" shall have the same meaning the term fiduciary has in the Act.

20. "Act"

The term "Act" means the Employee Retirement Income Security Act of 1974, as amended from time to time.

GROUP INSURANCE CERTIFICATE

AETNA LIFE INSURANCE COMPANY
Hartford, Connecticut

(Herein called the Insurance Company)

HEREBY CERTIFIES that Group Policy No. H-57267 has been issued to General Electric Company under which you are insured for the Comprehensive Medical Expense Benefits described in the

GENERAL ELECTRIC INSURANCE PLAN

As Set Forth In The Preceding

Certificate-Booklet Form ERB 201D

If you are an Employee, as defined in the Certificate-Booklet, you will become insured for Comprehensive Medical Expense Benefits in accordance with the provisions set forth in the Certificate-Booklet under the caption "Eligibility and Effective Date".

If you enroll for such insurance within thirty-one days of the date of your initial eligibility, your insurance will become effective on the date of enrollment if you are then at work. If such enrollment is made after such thirty-one day period, you must furnish (without expense to the Insurance Company) evidence of insurability satisfactory to the Insurance Company before you may become insured. If such evidence is submitted, you will become insured on the date the Insurance Company determines the evidence to be satisfactory. In any instance when you are both disabled (i.e., ill or injured) and away from work on the date you would become insured in accordance with the terms of this paragraph, the effective date of your insurance will be deferred until your return to active work.

The insurance providing the Comprehensive Medical Expense Benefits on account of your Dependents is appli-

cable only if you are eligible, have enrolled, and are insured, for such insurance.

There is certain further information relating to your insurance on the next page of this Certificate.

AETNA LIFE INSURANCE COMPANY

/s/ William O. Bailey
President

If Any Prior Certificate Relating to the Insurance
Referred to Herein Has Been Delivered to the
Employee Referred to Herein
Such Certificate is Void

ASSIGNMENT

The insurance and benefits evidenced in this Certificate are non-assignable except with respect to benefits payable for a loss incurred.

HEALTH INSURANCE CONVERSION PRIVILEGE

In the event of cessation of your Comprehensive Medical Expense Insurance because of termination of your service with the Company for any reason, you may arrange to obtain from the Insurance Company, without furnishing evidence of insurability, an individual policy for yourself or, if at that time you had insurance for your dependents under the Insurance Plan, an individual policy for yourself and such dependents in accordance with the following conditions. The individual policy may provide, at your option, Hospital Expense Insurance, or Hospital Expense and Surgical Operation Insurance or Comprehensive In-Hospital Insurance or similar type of policy then being issued for conversion purposes by the Insurance Company subject to the requirements of any applicable laws and regulations relating to the issuance of such insurance. The individual policy may be obtained by making application to and paying the required premium to the Insurance Company within thirty-one days after cessation of your Comprehensive Medical Expense Insurance, and shall become effective upon cessation of such insurance under the Plan.

At the option of the Insurance Company, the individual policy need not provide maternity benefits, nor benefits in excess of those under your Comprehensive Medical Expense Insurance. The individual policy may provide (a) for the exclusion of any condition excluded by your Comprehensive Medical Expense Insurance but not any other pre-existing condition; (b) for reduction of benefits thereunder during the first year to the extent that benefits will not exceed those that would have been provided had your Comprehensive Medical Insurance not

ceased; and (c) for reduction of benefits thereunder by any benefits payable under your Comprehensive Medical Expense Insurance after such insurance has ceased.

The Insurance Company will not be required to issue the converted policy covering any person if it is indicated that, at the date of termination he has similar coverage, or is eligible on a group basis for similar coverage, which together with the converted policy would result in overinsurance or duplication of benefits. The converted policy may provide that the Insurance Company may request, on any premium due date of such policy, information concerning the existence of similar coverage on any person covered thereunder, and if any such person fails to furnish details of such coverage when requested may take such coverage into account in determining benefits payable under the converted policy.

Your dependents may apply for individual policies under the same conditions as you, if they do so within thirty-one days after their coverage is terminated unless such termination was at your request.

You or your dependents may obtain information concerning the individual policies currently available for conversion purposes, and the applicable premium rates, as well as the proper application form, from your employee relations or personnel accounting office.

NOTICES TO EMPLOYEE

This Certificate and your Certificate-Booklet are valuable to you and you should keep them in a safe place. If you lose your Certificate-booklet, an additional copy may be obtained from your employer.

If you cease active work for any reason, you should find out from your employer what arrangements, if any, can be made to continue your insurance benefits in force, so that you will be able to exercise any rights you may then have.

The Home Office of the Insurance Company is located at 151 Farmington Avenue, Hartford, Connecticut 06156.

COMPREHENSIVE INSURANCE
California Supplement

Self-Insured Voluntary Plan

For Payment of Disability Benefits to
California Employees
Under Division I, Part 2
Of California Unemployment Insurance Code

Notice for California Employees

You will receive a separate document which sets forth the provisions of the Self-Insured Voluntary Plan for payment of disability benefits to California employees, if you are a California employee of General Electric Company or of a Company affiliate which provides the Self-Insured Voluntary Plan for its California employees.

General Electric Insurance Plan

To Our New Jersey Employees:

Plan ERB-201D sets forth the General Electric Insurance Plan as amended June 28, 1976. In accordance with the New Jersey Temporary Disability Benefits Law, the Plan includes Weekly Sickness and Accident Benefits payable under the Company's "Private Plan" of Temporary Disability Benefits which is outlined below. As a New Jersey employee your weekly benefit will not be less than an amount equal to two-thirds of your average weekly wage to a maximum weekly benefit of $117.00.

Because certain benefits provided under the "Private Plan" are not available to employees in other states, you will be required to contribute $.64 per month in addition to any contribution required under the General Electric Insurance Plan.

"Private Plan" of Temporary Disability Benefits

This notice outlines the "Private Plan" established in accordance with the Temporary Disability Benefits Law of the State of New Jersey. The benefits provided by the "Private Plan" are underwritten by the Metropolitan Life Insurance Company.

In compliance with the Temporary Disability Benefits Law of the State of New Jersey, as amended effective January 1, 1979, the following Weekly Benefits for disabilities commencing on and after January 1, 1979, are available under the "Private Plan" while you are employed by the Company and for the first two weeks thereafter, but in no event beyond the date you become employed by another covered employer.

Class	Weekly Benefit (See Note)
All Employees	The amount of Weekly Benefits shall be an amount equal to two-thirds of the Employee's average weekly wage * with a minimum Weekly Benefit of $10.00 and a maximum Weekly Benefit of $117.00. Such Weekly Benefit shall be computed to the next higher multiple of $1.00 if not already a multiple thereof.

* If the Employee's normal straight-time weekly earnings are $57.51 or more, the amount of Weekly Benefit shall not be less than $35.00.

The maximum Weekly Benefits specified above is applicable to periods of disability commencing in the calendar year 1979. Employees will be notified as of January 1 of each succeeding calendar year of the maximum Weekly Benefit applicable to periods of disability commencing in such year.

Note:—In the case of Salaried Employees the Weekly Benefit shall be:

(i) $15.00 during any period of disability while the Employee receives his regular remuneration during

absence from active work and prior to the day following (a) the day on which payment of such regular remuneration shall cease or (b) the day as of which such regular remuneration shall have been so paid to the Employee for twenty days in the preceding twelve months, whichever day first [occurs; and]

(ii) with respect to any other period of disability, an amount determined in accordance with the Schedule above.

Benefits payable while the $15.00 Weekly Benefit rate is applicable shall not be included in determining the maximum period for which Weekly Benefits are payable pursuant to the second following paragraph.

Any change in the amount of the Employee's insurance shall become effective in accordance with the provisions of the Group Policy, but in no case shall any change become effective on a date on which the Employee is not actively at work.

Benefits will start with the 8th day you are disabled as a result of sickness, accident or pregnancy (or with the 1st day of your confinement in a hospital as a bed patient, if earlier), and will continue during such disability up to a maximum of 26 times your weekly benefit rate. In addition, if weekly benefits for any one continuous period of disability are paid for three consecutive weeks, then benefits shall be paid from the first day of that period of disability.

In order to qualify for "Private Plan" benefits you must:

1. Be totally unable to perform the duties of your employment.
2. Be under treatment by a legally licensed physician, dentist, chiropodist or chiropractor.
3. Not be working for remuneration during your disability.

4. Not eligible for benefits for the same disability under any Worker's Compensation or Occupational Disease Law, or under any unemployment compensation or similar law.

If you cease work because of a strike, benefits shall not be payable for any period during which you would be disqualified from receiving benefits under subsection (i) of Section 15 of the New Jersey Temporary Disability Benefits Law if you were not covered under a Private Plan. However, the Company may, in its discretion, make appropriate arrangements to continue your coverage under this Plan during such strike.

The benefits described herein conform in all respects with the New Jersey Temporary Disability Benefits Law, and will never be less liberal than the benefits otherwise provided by said Law. You will receive a certificate to evidence the benefits granted you under the provisions of this "Private Plan."

GENERAL ELECTRIC COMPANY

Supplement ERB 199E/201 DW-3
Supplement ERB 199H/201 DW-3
Supplement ERB 199N/201 DW-3

General Electric Insurance Plan

To Our New York Employees:

Effective January 1, 1979, the following provisions replace the provision appearing in Supplementary Insert Form ERB-201D-X-1 of Certificate Booklet Form ERB-201D:

Plan ERB-201D sets forth the General Electric Insurance Plan as amended June 28, 1976. The level of Weekly Sickness and Accident benefits provided by this Plan is in excess of that required by the New York Disability Benefits Law.

In accordance with the provisions of such Law and notwithstanding any other provisions of the Plan, Weekly Sickness and Accident coverage under the Plan is continued for a period of four weeks after your employment terminates, but in no event beyond the fifth day of such period on which you perform any work for remuneration or profit or the first day on which you perform work for any employer covered by the Disability Benefits Law.

Because this Plan provides benefits, as required by the New York Disability Benefits Law, that are not available to employees in other states, you will be required to contribute 13¢ per month in addition to any contributions required under the General Electric Insurance Plan.

GENERAL ELECTRIC COMPANY

Supplement Insert ERB 199E/201 D-X-2
Supplement Insert ERB 199H/201 D-X-2
Supplement Insert ERB 199N/201 D-X-2

General Electric Insurance Plan

To Our Rhode Island Employees:

Effective January 1, 1979, the following provisions replace the provisions appearing in Supplementary Insert Form ERB-201D-Y of Certificate Booklet Form ERB-201D:

Plan ERB-201D sets forth the General Electric Insurance Plan as amended June 28, 1976. For our Rhode Island employees, the Weekly Sickness and Accident benefits shown in the booklet will continue to be modified as follows to take into consideration benefits of a similar type provided under the Rhode Island Temporary Disability Insurance Act.

The Weekly benefits provided by the Insurance Plan will continue to be reduced by the actual amount of Rhode Island benefits payable (including any dependent allowance) for any disability.

Deductions will continue to be made for coverage under the Rhode Island Temporary Disability Insurance Act effective January 1, 1979, at the rate of 1½% on the first $4,800 of earnings. However, these deductions will be reduced by a credit which will be provided by the Company so that the maximum deduction will be $9.40 in 1979 and subsequent years. This credit is provided so that Rhode Island employees will be on an equitable basis with the employees in other states with respect to the General Electric Insurance Plan.

GENERAL ELECTRIC COMPANY

Supplement Insert ERB 199E/201 D-Y-1
Supplement Insert ERB 199H/201 D-Y-1
Supplement Insert ERB 199N/201 D-Y-1

EXHIBIT 9

AGREEMENT

on

EMPLOYEE BENEFIT

PROGRAMS dated September 6, 1976

between

The B.F. Goodrich Company

and

International Union of
The United Rubber, Cork,
Linoleum, and Plastic
Workers of America
AFL-CIO-CLC

and

Local Unions

No. 5, Akron, Ohio	No. 351, Tuscaloosa, Ala.
No. 715, Ft. Wayne, Ind.	No. 318, Miami, Okla.
No. 241, Marion, O.	No. 281, Oaks, Pa.

[UNION LABEL]

Article 12 (Cont.)

* * * *

customary charges therefor or in excess of such charges as would have been made in the absence of this program. A customary charge means the usual charge made by the person, group or other entity rendered or furnishing the services, treatments or supplies but in no event will it mean a charge in excess of the general level of charges made by others rendering or furnishing such services, treatments or supplies within the area in which the charge is incurred, for illnesses comparable in severity and nature to the illness being treated. The term "area" means a county or such greater area as is necessary to obtain a representative cross section of persons, groups or other entities rendering or furnishing such service, treatment or supply.

(d) Mental, Psychoneurotic or Personality Disorder Conditions: As to Covered Expenses resulting from mental, psychoneurotic or personality disorders incurred while the Family Member is not confined in a hospital on an inpatient basis, any benefit payable with respect to such expenses after the deductible will only be included to the extent of $30.00 for professional services rendered during each such visit, and will be at the rate of 50% subject to a seven hundred fifty ($750.00) dollars calendar year Maximum Benefit.

(i) Covered Expenses shall include charges actually made to a Family Member for services of a clinical psychologist in connection with the diagnosis or treatment of any mental, psychoneurotic or personality disorder of such Family Member which would apply if such services were rendered by a physician.

(ii) "Clinical psychologist" means a person who provides clinical psychological services in connection with the diagnosis or treatment of mental, psychoneurotic or personality disorders, and who qualifies as a psychologist, in any of the following ways in the jurisdiction (state, District of Columbia, territory or possession of the United States, or province of Canada) in which he is practicing:

If statutory licensure or certification of psychologists exists in the jurisdiction, he holds a valid license or certificate of such jurisdiction as a psychologist.

If statutory licensure or certification of psychologists does not exist in the jurisdiction, he holds a valid, non-statutory (professional) certification established by the jurisdiction's recognized psychological association.

EXHIBIT 10

Columbus, Ohio 2/26/79 Page 38
Union Proposal—BFG System—1

ARTICLE 12—Continued

12.7 (c) (v) (Continued)

(a) No change

(b) No change

(vi) No change

(vii) No change

(d) Amend to read as follows:

Mental, Psychoneurotic or Personality Disorder Conditions: As to Covered Expenses resulting from mental, psychoneurotic or personality disorders incurred while the Family Member is not confined in a hospital on an inpatient basis, any benefit payable with respect to such expenses after the deductible will only be included to the extent of $50.00 for professional services rendered during each such visit, and will be at the rate of 50% subject to a one thousand ($1,000.00) dollars calendar year Maximum Benefit.

(i) No change

(ii) No change

(e) 1st paragraph—No change

2nd paragraph—amend to read as follows:

Room and board in an approved Convalescent Nursing Home, and other services and supplies furnished by an approved Convalescent Nursing Home for Medical care, exclusive of professional services will be considered covered expenses if

the covered individual has been confined in a hospital for at least three (3) days and then admitted to such Convalescent Nursing Home following the hospital confinement upon the written recommendation of the attending physician certifying that the patient's condition would require hospital confinement if Convalescent Nursing Home care were not available. Readmission, upon the attending physician's recertification, to such Convalescent Nursing Home following discharge will be considered a continuation of the same confinement for purposes of this Paragraph.

EXHIBIT 11

12.3(a)(v)	Add two new procedures in lieu of surgery: Immunotherapy for malignant disease Ultransonography
12.4	Increase amounts from $18 to $25 and from $12.50 to $17 for in-hospital doctors' visits.
12.7(b)	Increase Major Medical limits from $50,000 to $75,000 annual maximum and from $200,000 to $300,00 lifetime maximum.
12.7(d)	Increase allowances for mental/psychoneurotic outpatient treatment from $30 to $45 per visit and from $750 to $1,125 annually.
12.7(k)(1)(b) and 12.7(k)(1)(c)	Revise retiree Major Medical Deductible provisions to be compatible with changes in 12.15(h), Special Medicare Benefit.
12.9(c)	Amend to reflect change in 12.10.
12.10	Amend to provide 24 months of continued Company-paid medical coverage in the event of Plant Closure.
12.13(a)(4)	Provide automatic coverage of spouse and dependents for medical benefits if employee dies after attaining 25 years of service, regardless of age. Under the 1976 Agreement, such coverage was available only to employees eligible for retirement.
12.14	Language revised to allow coverage for newly acquired spouse and dependents of a retiree who marries, or remarries, after retirement. In the event of the retiree death, coverage to the new spouse and dependents continued only if married for one year, or more.

12.15(c)	Add "Chiropractor" to definition of physician.
12.15(h)	Employees who are age 65 or over; eligible surviving spouses and employees otherwise eligible for Medicare Part B will automatically receive the Special Medicare Benefit.
12.16(f)	Provides co-ordination of benefits with Medicare for any Pensioner, employee, or dependent on whose behalf the Special Medicare Benefit was paid.
ARTICLE 13	Sickness and Accident Program
13.1	Increase amount of Sickness and Accident Benefits from $110 to $125 per week.
13.2	Provide for benefits to be payable for pregnancy or related conditions the same as for any other medical condition, removing the maximum of six weeks of payments.
13.10(c)	Add language to allow a Chiropractor acting within the scope of his license, to certify a disability under the Sickness and Accident Program.

EXHIBIT 12

AGREEMENT

between

GTE SYLVANIA, INC.
for its Loring Avenue,
Salem, Massachusetts, Plants

and

INTERNATIONAL UNION OF
ELECTRICAL, RADIO & MACHINE
WORKERS, IUE (AFL-CIO)

September 3, 1973 through
November 15, 1976

[UNION LABEL]

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* * * *

"Covered medical expenses", when used in this Section for covered disabilities shall mean reasonable charges for medical services when required in the treatment of an illness. With respect to such services necessarily rendered in the hospital, such term shall include: (1) all room-and-board charges up to a maximum of $6.00 per day above the hospital's most common semi-private room rate and (2) all miscellaneous charges made by the hospital. With respect to such services which may be rendered either in or out of a hospital, such term shall include: (1) Physician's services for surgical and medical care and treatment; (2) nursing care by a trained nurse (one who has sufficient training in the opinion of the attending physician to care for the patient) when ordered by physician, except a nurse who is a relative or one who lives in an employee's home unless she is actively on the applicable registry and she is assigned to the case in accordance with the usual procedure; (3) emergency transportation services (within the United States of America and Canada) by ambulance, regularly scheduled airline or railroad from the point where disabled, to or from a hospital qualified to provide special treatment for the condition, but not more than one trip to and one trip from the hospital in any one benefit period on account of any one accident or sickness; (4) x-ray examination and x-rays, radium and radioactive isotope treatments and laboratory tests or analyses if incurred upon the recommendation and approval of the attending physician; (5) anesthetic and its administration if incurred upon the recommendation and approval of the attending physician; (6) prescription drugs, bandages, surgical dressings, surgical supplies, oxygen and rental of equipment to administer oxygen, rental of wheel chair or hospital type bed and rental of iron lung or other equipment for treatment of respiratory paralysis if incurred upon the recommendation and approval of the attending physician; (7) blood, plasma and cost of administration if incurred

upon the recommendation and approval of the attending physician; (8) charges incurred on account of nervous or mental disorders while a person is confined in a hospital; (9) charges up to $12.50 per visit for no more than fifty visits with respect to a benefit period incurred for out patient psychiatric care and treatment of a disability provided that such treatment is rendered by a licensed psychiatrist; (10) charges incurred for Caesarean section and operation for extra-uterine pregnancy and subsequent expenses incident thereto and charges incurred for severe medical or surgical complications arising out of pregnancy, childbirth or miscarriage and subsequent expenses incident thereto, over and above the charges actually incurred for miscarriage, normal pregnancy, or normal childbirth; provided, that such charges shall be included only in the event the person is entitled to maternity benefits under the Basic Medical coverage referred to in Section D hereof; and provided further, that no other charges incurred in connection with pregnancy, childbirth or miscarriage shall be included; (11) charges incurred in connection with any dental work or procedures, eye refraction, eye glasses, hearing aids or the fitting thereof which are required on account of accidental bodily injury to physical organs or parts, sustained while the person is insured hereunder and (12) dental surgery procedures covered under Basic Medical Insurance referred to in Section D hereof.

* * * *

EXHIBIT 13

AGREEMENT

between

GTE SYLVANIA
INCORPORATED
for its Loring Avenue,
Salem, Massachusetts, Plants

and

INTERNATIONAL UNION OF
ELECTRICAL, RADIO & MACHINE
WORKERS, IUE (AFL-CIO)

September 10, 1976
through
November 15, 1979

[Union Label]

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* * * *

11) The schedule of procedures for the diagnostic procedures benefit shall be increased to double the present schedule with a maximum of $150 for any and all sicknesses.

The outpatient psychiatric benefit for employees only shall be improved to provide:

a) payment for the full cost of the first two visits to a clinic or psychiatrist based on reasonable charges,

b) payment of $34.00 for remaining visits to a psychiatrist or $17.00 for clinics.

c) that payment for visits to a clinic or psychiatrist will be limited to the first two visits mention in a) above and an additional fifteen visits mentioned in b) above per twelve month benefit period.

d) that a "clinic" will qualify for coverage only if it is affiliated with a state licensed hospital.

* * * *

EXHIBIT 14

AGREEMENT

between

GTE SYLVANIA
INCORPORATED
for its Loring Avenue
Salem, Massachusetts, Plants

and

INTERNATIONAL UNION OF
ELECTRICAL, RADIO & MACHINE
WORKERS, IUE (AFL-CIO)

September 3, 1979
through
November 15, 1982

[UNION LABEL]

APPENDIX

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SCHEDULE "D"

EMPLOYEE GROUP INSURANCE AND BENEFIT PLANS

The Company will maintain employee group insurance and benefit plans during the term of this Agreement of the following types: life insurance, accidental death and dismemberment insurance, non-occupational disability insurance, non-occupational basic medical insurance, non-occupational major medical insurance and dental assistance plan.

These employee group insurance and benefit plans will be administered solely by the Company. No matter concerning the foregoing or any difference arising thereunder, shall be subject to the grievance or arbitration procedures of this Agreement but rather shall be governed by the terms and conditions of the contracts issued by the Insurance Company to provide these coverages.

Effective September 3, 1979 the employee group insurance and benefit plan will be improved to provide the following:

* * * *

4) Out-patient mental and nervous coverage will be extended to covered dependents;

* * * *

EXHIBIT 18

MANDATED HEALTH INSURANCE COVERAGE— A STUDY OF REVIEW MECHANISMS

Report to the
Bureau of Insurance
State of Virginia

by

John G. Larson, Ph.D.

Department of Health Administration
School of Allied Health Professions
Medical College of Virginia
Virginia Commonwealth University

1979

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ACKNOWLEDGEMENTS

The author would like to acknowledge with gratitude the valuable assistance provided by officials with the following organizations:

Aetna Life and Casualty

Association of Blue Cross-Blue Shield Plans

Blue Cross-Blue Shield of Colorado

Blue Cross-Blue Shield of Southwest Virginia

Blue Cross-Blue Shield of Virginia

Blue Cross of Maryland

Bureau of Insurance, State of Virginia

Commissioner of Insurance, State of Connecticut

Ford Motor Company

Health Insurance Association of America

Life of Virginia

Medical Society of Virginia

Reynolds Metals Company

Virginia Department of Commerce

Virginia Department of Health

Virginia Department of Mental Health and Mental Retardation

Virginia Hospital Association

INTRODUCTION

Purpose of Study

The Virginia General Assembly has been in the past and is presently being petitioned to mandate coverage for additional benefits and services of newly licensed health care practitioners. The problem is that such significant decisions are being made without any systematic assessment of the impact on the cost, quality of medical care, and the structure of the health care delivery system in Virginia. Virginia legislators lack the benefit of a critical evaluation of these important factors. The purpose of this study was to demonstrate the consequences of what generally appears to be insignificant decisions (regarding passage of mandated coverage) and to define criteria and an approach for evaluating the appropriateness of proposed mandated coverage legislation.

Scope and Approach

Specific proposals for mandated coverage by any groups in the state of Virginia or elsewhere were *not* evaluated. In no part of this study can the consultant be responsible for assessing the various legal issues nor any legal considerations which might be a part of a proposed mechanism or criteria.

An initial step in this study was to conduct a literature review with emphasis on general topics of mandated coverage and various related issues. Secondly, national organizations, such as the Health Insurance Association of America and the Association of Blue Cross-Blue Shield Plans, were contacted to gain benefit of their research and conclusions regarding the study topic. A third step was to interview various officials according to an interview guide focusing on trends in mandated coverage, problems with current review process, desirable changes in health insurance coverage, role of health insurance, alternative review mechanisms, considerations when re-

imbursing new practitioners, and activities in other states. Among those interviewed were officials with Blue Cross-Blue Shield, selected commercial insurance carriers, Virginia Department of Health, Virginia Department of Mental Health, provider groups, large employers, and others in and outside the state of Virginia.

The report is a synthesis of the current literature and input from the many parties interviewed.

Chapter I

TRENDS IN MANDATED COVERAGE

Nationally

Beginning in the Sixties there has been a trend throughout the nation for state legislatures to mandate various forms of additional health insurance coverage. Mandated coverage legislation requires all private insurance carriers to include in all accident and sickness policies sold in the respective state some form of additional benefit or coverage. The legislation may require that it be included as an option or required component. Generally speaking, the legislation is intended to increase the array of benefits or pay for practitioners' services which have formerly not been subject to the third party reimbursement.

Mandated coverage legislation throughout the United States requires private health insurance carriers (includes commercial insurers and Blue Cross and Blue Shield plans) to either provide or offer coverage for the following benefit categories:

1. Alcoholism and/or Drug Abuse
2. Catastrophic Coverage
3. Continued Coverage—Mandated Conversion
4. Dependent Coverage
   - Mentally and/or physically handicapped children

- Newborns
- Other, i.e., students, widows, spouses, etc.

5. Maternity Coverage
6. Mental and/or Nervous Conditions
7. Miscellaneous Benefits
8. Out-of-Hospital Care
9. Practitioners' Services

Treatment of alcoholism, drug abuse, and mental and/or nervous conditions represent empirically a very large part of the trend in mandated coverage legislation. Certainly, these are the more controversial categories of mandated coverage legislation. An employee benefits consultants' report shows that 20 different states have mandated coverage of alcoholism to some extent; 17 different states, mental and/or nervous conditions; and eight different states, drug abuse.[1] It must be recognized that approaches to mandated coverage vary from state to state. Since most of this legislation was enacted within the last five years, it is interesting to note that there has been a swing from legislation requiring provision of additional coverage to the lesser requirement that it be an option offered in all policies. Given the controversial nature of this legislation, legislators have no doubt found that optional coverage legislation is easier to pass and less likely to create an adverse reaction among their constitutents.

Statistically, catastrophic coverage is not a signfiicant trend; nevertheless, it is a recent initiative taken by a few states to address issues normally reserved for national strategists and their national health insurance proposals.

Dependent coverage is intended to address a problem of variability or lack of uniformity in benefits in policies which often appear to the public as similar. In many states, health insurance policies were being sold

that did not cover newborns, handicapped children, and so-called others, e.g., students, adopted children, and spouses. Newborn coverage has been mandated in many after reports that some insurance companies have denied coverage of newborn children with cogenital birth defects. It is a move to insure uniformity of coverage.

Some of the maternity coverage legislation is aimed at requiring that all complications of pregnancy be treated like sickness and injury under medical expense plans. The Pregnancy Disability Benefits Amendments to the Civil Rights Act (P.L. 95-555) recently signed into law requires that pregnancy-related medical conditions must be treated the same as other medical conditions under any health or disability insurance plan available in connection with employment.[2]

Out-of-hospital care category of mandated benefits includes payment for home health care services, outpatient surgical services, and a variety of other ambulatory services. The lack of reimbursement for purportedly less expensive ambulatory care services has been cited as a primary cause of the emphasis on acute care services and resultant inflation. This type of legislation is attractive to legislators given a concern over the rise in hospital care expenditures.

Practitioners' services legislation does not create any additional benefits for subscribers, but merely requires private insurers to reimburse additional practitioners (non-physicians) for services under present coverage, thus often characterized as "self-interest" legislation. This form of mandated coverage has increased since the Medicare program included various non-physician practitioners as eligible providers. These practitioners range from optometrists to clinical social workers.

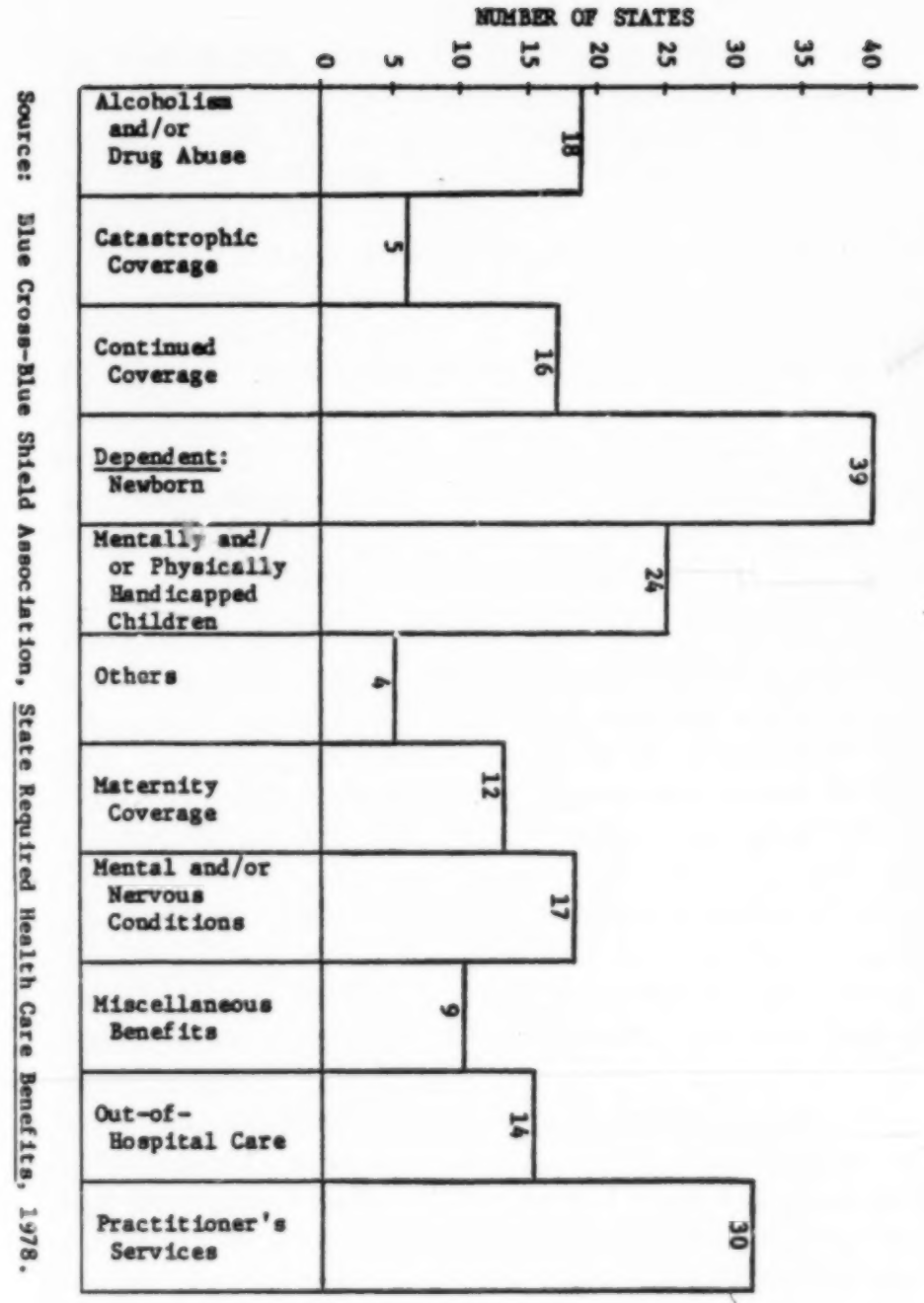
A tabulation of all mandated coverage legislation per state and year of passage can be found in Appendix A. Also, on the next page a chart illustrates mandated cover-

age legislation passed by a number of states. It does not include legislation much beyond 1977. Nevertheless, it demonstrates the trends throughout the nation.

Virginia

In Virginia, there was a rash of mandated coverage legislation starting in 1976. Coverage of newborns was mandated in 1976. During the same legislative session a law mandating coverage for mental disorders was passed. In 1977 this law was amended to require the offering of outpatient psychiatric benefits in all health insurance contracts. Concurrently, a mandated coverage bill was enacted requiring private health insurance carriers to offer coverage for inpatient and outpatient care for alcoholism and drug addiction under group and non-group family contracts.

DISTRIBUTION OF MANDATED COVERAGE BY NUMBER OF STATES - 1977



Source: Blue Cross-Blue Shield Association, State Required Health Care Benefits, 1978.

Future Trends

It is likely that a number of trends will emerge nationally. One is that there is likely to be an increasing number of mandated coverage bills passed which require additional coverage as an option. Secondly, the number of proposals to mandate practitioners' services will grow proportionally at a higher rate than other categories. Thirdly, the current interest in cost containment will generate renewed interest in mandating out-of-hospital care coverage, as reduced utilization of acute, inpatient services is a goal common to all cost containment strategies. Finally, social activist groups will attempt to use mandated benefit legislation as a means to indirectly influence public policy on controversial social and moral issues, such as abortion and women's rights.

These future trends are likely to be evident in Virginia, particularly practitioner services bills. During coming sessions of the General Assembly, the legislators may consider proposals to mandate coverage, or better said, payment of services rendered by a number of allied health practitioners, particularly in the mental health services field. The latter has been openly encouraged by the President's Commission on Mental Health. Proposals for mandating out-of-hospital care will remain evident; however, it is questionable whether they will achieve any significant political support. Accordingly, mandating uniform coverage of nursing home care, ambulatory surgery, home health services, or hospice care are likely proposals. These proposals demand close examination, since the change in reimbursement is not always apparent. Outpatient surgery is a good example. Many insurers already cover outpatient surgery by paying the surgeons' fees, but not the ancillary services. The interest behind the "surgi-centers" proposals in various state for mandating coverage of outpatient surgery is to achieve more comprehensive reimbursement arrangements beyond payment of surgeons' fees.

Chapter II

CONTRIBUTING FACTORS

The factors underlying the trend of mandating expanded health insurance coverage are numerous and identification varies according to the perspectives of each interested party—insurance executives, providers, and employers. Most are complex and will not receive a comprehensive explanation here, other than to demonstrate how each might be considered a causal factor. Factors identified during this study are listed below:

- Incomplete health insurance coverage
- Expanded definition of health
- Anti-physician sentiment
- Expanded number and types of practitioners
- Changing values and expectations of society
- Pressure to reduce taxpayers' burden
- Health insurance role as a change agent

Each will be addressed briefly in this chapter.

Incomplete Coverage

The trend is toward broad comprehensive coverage as reflected in the expansion into non-basic types of benefits and the growth of major medical coverage, which provides broad high-benefit-level coverage against many prescribed health care services. As comprehensive coverage contracts have become more prevalent, it has been adopted as the norm by which all coverage is judged. The point is that the perception of "gaps" varies according to the norm employed. How one defines the role of health insurance (to be discussed later) impacts on the definition of the norm. A more conservative approach may be to define the norm as a minimum benefit package.

Whatever the approach there are generally agreed upon unacceptable gaps in private health insurance coverage. One such example, which has resulted in a spate of mandated coverage laws throughout the nation was the lack of newborn coverage in policies sold in Virginia and most other states. Many young parents falsely assumed that they had such coverage and found out later when confronted with sizeable medical bills for the care of a sick newborn that this was not true at all. One might argue that this is a matter of personal responsibility; however, when purchasing health insurance, the average consumer is not an "informed buyer" and cannot be expected always to make a rational decision. Most consumers are not aware of what is adequate health insurance coverage, nor what existing policies provide. The definition of adequate coverage is dynamic and is a function of the life-saving potential of medical care and the attendant costs. Part of the reason behind the need for newborn coverage is the development of neonatal intensive care units. The recent improvements in the care of the sick newborn (e.g., premature infants) are impressive, but the costs are usually catastrophic.

Absence of newborn coverage for many families would be a source of substantial risk exposure. If the purpose of insurance is to alleviate the sizeable forms of personal financial risk, one might assume this should be a part of the basic health insurance package. A significant number of family health insurance policies with maternity benefits excluded newborn infants from the moment of birth up to 14 or even 30 days of life. The latter is the interval of highest risk; therefore, many insurers have avoided writing this form of coverage to minimize high-risk exposures. In some cases the newborn coverage was so ambiguously presented that families falsely assumed they possessed adequate coverage. The necessity for legislative intervention seemed apparent. This whole issue becomes more complex when reviewing the wide range of

opinions regarding the role of health insurance and the definition of health.

Expanded Definition of Health

As the capability of medical science expands, a corresponding re-definition or expansion of the concept of health has taken place. The World Health Organization Charter defines health as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[3] This seems to give the definition of perfect health no bounds, so it may be considered to be a feeling of ebullient well-being that causes one to burst into song with joy. This ideal state is only achievable for very brief periods. It is unrealistic and not likely to be achieved through the most sophisticated mental health programs. A way of defining health is to conceive of it as a range of possibilities. One extreme is death which is readily definable. Moving towards the other extreme through total disability, partial disability, and minor impairments towards perfect health does not establish a finite end point. Inevitably, perfect health is subject to individualistic interpretation and rarely achieved.

A more pragmatic approach is to deal with the subject in terms of poor health. This is a state of health so poor that it produces a need for treatment or impairment of productive function. Then, what is a need? If perfection is the goal, any condition for which a remedy is available constitutes a need for treatment. This is not much help. For practical purposes, a need for treatment should be defined as a physiological or mental condition which, in the light of current knowledge, the current resources of society, and the opinions of competent physicians, should receive treatment. Consequently, concepts of needs would be expected to change over time as does current knowledge and applied technology regarding the diagnosis and treatment of physiological and mental conditions. Before a need can be translated into action,

there must be a recognition of the need which may not seem problematic at first. The problem is that recognized need or consumer wants outstrips the present availability of resources. The concept of impairment of productive function is also somewhat vague. Productive function may be impaired by serious injury or disease or by chronic, relatively minor, ailments such as fatigue, constipation, indigestion, a dull headache, congested nasal passages and nervousness. By such a standard, most people's productive functions are impaired every day. There must be a practical criterion, thus the concept be restricted to impairment so severe as to cause a noticeable restriction of normal activity. Poor health may be defined as any physical or mental impairment which requires treatment in the opinion of an accepted medical practice or results in an observable restriction of normal activity. This certainly approaches more the "medical necessary" concept, which receives the strong endorsement of the insurance companies. The practitioner prefers a more fluid definition which preserves a sense of hope and faith in the endless possibilities of medical science; conversely, the insurers approach the subject with more economic pragmatism. This kind of conflict between goals and values in society today is the mother of government intervention. As shown earlier, much of the mandated coverage legislation is a result of expanding comprehensive coverage to include a wider range of mental health services. This is a predictable result of increasing acceptance that the health care delivery system bears some responsibility in insuring mental and social well-being.

Greater Expectations of Society

This may appear redundant, vis-a-vis the expanded definition of health section; however, the former section is a result predominantly of the professionals' or health care providers' changing definition of need. Society's ex-

pectations are certainly conditioned by the providers' choices or preferences regarding treatment modes. Nevertheless, changing societal values affect what is deemed a collective responsibility of society regarding individual risk that should be minimized through public and/or private insurance. Traditionally, alcoholism, drug abuse, and mental disorders were commonly viewed as instances of individual failure. It was considered a result of self-abuse and lack of control; therefore, the consequences should be a personal responsibility. Today, a more egalitarian philosophy has fostered the belief that society has responsibility for protecting such unfortunate individuals as well as society as a whole, since the negative impact is perceived to go beyond the domain of the unfortunate individual. Also, this may be a result of the growing magnitude of these health problems. Consequently, there is greater acceptance, even with the lack of strong consumer advocacy, of the inclusion of coverage for such problems in health insurance policies. A similar example is in the support of comprehensive coverage of maternity and newborn care. The belief is that a good outcome of pregnancy and post-natal care increases the chances for a good citizen, meaning a healthy and productive one.

Expanded Number and Types of Licensed Practitioners

Since the Sixties, there has been a proliferation of autonomous practitioners in the health care industry. Examples are clinical social workers, nurse practitioners, pastoral counselors, nurse midwives, alcoholism counselors, and so on. Many of the new allied health professions were spawned from theories to increase the access to health care services, lower cost, expand the productivity of physicians, and overcome shortages of selected health manpower, mainly physicians. For reasons of professional accountability and legal liability and the tradition that the physician remain the "gatekeeper" of the health care system. The physician controls entry into the system and provides the only pathway through the

system. Furthermore, the payment system has reinforced this arrangement. Given role expectations and tremendous variability in practice opportunities throughout the nation, these allied health professionals have been frustrated and rebellious towards the traditional medical model. Most believe that they cannot fully maximize their potential contribution according to their professional skills and knowledge. No doubt this dependency role has circumscribed what they would like to achieve economically and professionally. Consequently, these professional groups have been pushing for greater recognition as autonomous practitioners.

Today's society attributes the greatest prestige and status to the autonomous professional. The physician is the epitome of this. In pursuit of this standing in society, the new non-physician practitioners have sought licensure which entitles them to collect a fee for specific services. A natural question after this is why cannot he or she be reimbursed by the patient's insurance company? Few have been successful through petitioning insurance companies, so the next avenue has been to take the issue to the courtroom or the legislature to mandate payment. The insurance companies have resisted due to their concept of what is the role of health insurance and the need to maintain control through the "medically necessary" model.

Anti-Physician Sentiment

Some attribute the success of non-physician practitioner groups to gain passage of mandated payment legislation to anti-physician sentiment. This is not to give any credence to this, merely to recognize it as a force. Today, we have insurance companies paying medical specialists for professional services, even though they clearly recognize that in some instances almost one hundred percent of the service is being rendered by a non-physician practitioner. In theory the medical specialist is receiving a

fee for his clinical supervision. It is a problem when the physician does not appear to be exercising a proper degree of involvement. A common example cited by social workers in many states is an adult may meet with a psychiatrist to discuss apparent psychological problems. Treatment may be recommended; and, then the individual is turned over to a clinical social worker for therapy, and the psychiatrist may never involve himself in any visible way in the therapy program. A key word is visible, since the consumer does not see the psychiatrist being involved, so the conclusion is that the higher fee is inappropriate given the level of apparent professional input. The social worker may feel that he or she is not getting a just share of economic rewards, but more importantly the level of professional recognition is not commensurate with the level of input. As a result, we have social workers pushing for independence and individual reimbursement with consumers often backing them. This example does *not* represent the rule, yet such instances have fueled the antagonism.

Generally, the medical profession has not supported the mandated payment bills. The example cited earlier has led critics to say that physicians' opposition is derived out of economic self-interest. However, some evidence demonstrates that physicians' incomes are seldom affected due to infinite elasticity of demand. The same attack can be just as easily levelled at the proponents, but such comments skirt the legitimate, more prevalent concerns af all interested parties—i.e., costs and quality control.

Pressure to Reduce Taxpayers' Burden

As mentioned earlier, society's expectations and the expanding capabilities of medical science have created a need for more private and public health programs. In an era of "Proposition 13" there has been growing reluctance on the part of legislators to expand public programs to address problems, such as alcoholism, drug abuse, and

mental illness. Private sector programs in these areas have increased rapidly during the last decade.

It may be easier to mandate expanded private insurance coverage, rather than raise taxes to sponsor such programs. The belief is that the public sector is shifting such service responsibilities to the private sector as well as financial responsibilities, i.e., mandated coverage bills. It is deemed to be a form of "hidden taxation."

Health Insurance as Change Agent

The health care delivery system in this nation and the state of Virginia is beset with a number of problems. Frequently identified problems are rising costs, unnecessary utilization of expensive facilities and services, maldistribution of health manpower, and difficult access to primary care services for segments of the population. Often third party payment is the basis of a strategy for devising a scheme of incentives and disincentives to influence patterns of practice or allocation of resources. Put very simply, the technique is to make it economically advantageous for a physician, other practitioners, and consumers to utilize precious resources in a more prudent fashion.

Chapter III

IMPACT OF EXPANDED INSURANCE— CONCEPTUAL OVERVIEW

The focus of this study is to conclude on an improved approach to evaluation of mandated coverage proposals. A thorough evaluation must assess the probable impact of each mandated coverage proposal on premium costs, utilization levels, and total health care expenditures. This chapter presents an overview of what in the past has been the impact of expanding health insurance coverage.

One factor that conditions the estimation of impact is the evaluators' viewpoint regarding the role of health insurance. One extreme view may be that the health care system is essentially sound, and that the role of health insurance is to provide protection against unpredictable and significant financial risk. The other is that there really is a health care crisis and insurance should be used as an instrument to facilitate change, as well as provide income protection.

Regardless of the points of view it is more important, given the subject of this study, to understand the effects of expanded coverage. There are three. First, it usually lowers the out-of-pocket costs to the consumer for use of covered services. Secondly, when the out-of-pocket cost is lowered, the consumer has more cash to expend on non-covered health care services. Finally, it assures a flow of revenue to providers. This is usually greatest on a fee-for-service arrangement. The behavior of providers and clients is altered by these effects much as anyone would anticipate. The expected result are changes in the volume, content, and distribution of health services provided. This would be manifested in five ways, as follows:

1. Consumers use more covered services, and this also generates expansion of complementary services which the consumer is more able to afford.

2. A greater volume of services are utilized. Anyone who was not previously covered is more likely to use services if coverage is expanded to them. Also, the service is enriched through increased technological content and amenities.
3. The tendency is to increase and enrich those services covered by insurance and substitute those covered by services for those services that are not covered or only partially.
4. The use of non-life sustaining or less urgent services will increase since demand for these services is accelerated by lowering the out-of-pocket expense.
5. Also, there may be some increased use of preventive care services, if covered and out-of-pocket expense for these services more closely approach zero.[4]

In summary, expanded coverage will result in higher rates of utilization, an enriched health care product (i.e., greater use of expensive technology or more amenities), and some potential for redistribution of health care services or manpower to the otherwise deprived segments of the population. An important consideration in this age of scare resources is the trade-offs.

The trade-off can be assessed by the change in prices and total expenditures. A rise in prices is predictable since expanded coverage creates greater demand pressures on limited service capacity. Also, any changes in the health care product through improvements, whether new technology or amenities, will force the price of the covered services up. Total expenditures are increased by the dual upward movement of prices and volume. In the past, expanded insurance coverage has resulted in the provision of the more expensive services, rather than encourage the substitution of less expensive forms of treatment when equally effective. The total subtle effect of expanded coverage is, as the increased prices and expenditures become a financial burden on consumers in the form of greater out-of-pocket expenditures and increased premiums, a renewed movement to expand coverage is generated. The need for expanded coverage has no limits; there are merely pauses. This does not mean the genuine social problems which spawn proposals for expanded coverage be ignored, rather that each decision be made in a very circumspect fashion. The immediate impact of any one decision usually appears to be minor; yet, as shown here, the long-term effects may be even more threatening to the very individuals that you are striving to help.

Another important point is that features of the health care system often limit the potential effectiveness of changes in health insurance in achieving certain objectives. Changes in health insurance are pursued for any number of reasons. Some objectives frequently identified by proponents of state mandated benefits will be discussed here to demonstrate what might be the more predictable consequences. These objectives are financial protection of individuals, improvement in the quality and quantity of health care services and reduction of costs through emphasis on out-of-hospital care.

No one would disagree that an objective of health insurance is to protect subscribers from the unpredictable costs of illness. Controversy arises over whether it is the only objective or simply the minimum purpose. There are two points to be addressed regarding income or financial protection. First, according to the classical definition of insurance it should be to protect individuals from unpredictable expense. Consumers want insurance that will protect their assets and style of living from all medical expenses. He would rather not make any further sacrifice than regular payment of a premium. The other point is that consumers expect the cost of protection (premium) to be at a reasonable level. The criterion for this is that

annual premium expense will not reach a level where the consumer must sacrifice the consumption of other goods and services. These two purposes inevitably conflict. As the level of insurance protection approaches absolute financial security, the cost of protection becomes exorbitant.

Judging the adequacy of protection provided by some form of insurance coverage is very difficult. It depends on how the health care services are consumed, in what order, how often, and the degree of medical necessity. A simpler approach is a measure of the consumers' liability. This may be done by setting a specified percentage of disposable income. The percentage figure may have to vary since our sense of equity may dictate that the poor should bear a smaller percentage of their disposable income.

Another important consideration is, as mentioned earlier, that increased coverage will encourage greater use of service and contribute to a rise in prices and total expenditures, particularly important an increase in health insurance premiums. In summary, great care has to be taken in pushing for increased protection as it creates a vicious cycle. Greater protection may result in increased expenditures which over the long run may result in the need for more protection. All the while premiums are increasing, thus demanding a progressively increasing share of the consumers' disposable income.

Improvement in the quality and quantity of health services is a frequently espoused objective for mandatory coverage. As stated earlier, a predictable consequence of expanded coverage is increased usage and an enriched product. This does not necessarily mean people will receive better care. Simply paying more for the same services without attention to the process will result in diminishing returns to scale. Contemporary thinking is focusing on the fact that consumption of health care

services does not result in better health. In fact, there is some possible loss due to iatrogenic disease and dimunition of resources devoted to improving our standards of living.

A frequent argument for modifying coverage is to pay for more out-of-hospital care, e.g., outpatient surgery and home health services, thus reducing costs. Regrettably, experience has shown the latter not to be true. Expanded coverage has resulted in much greater consumption of the newly covered service and rapid expansion in capacity of these services without a corresponding reduction in hospital usage. Total costs go up! It appears that in some cases hospital usage increased. Appropriate controls must accompany the expanded coverage to reduce hospital usage and capacity, thus costs may decrease or at least stabilize.

Another objective may be to achieve a better allocation of resources among the types of health care services. To be economically sound the allocation of resources to less serious or vital services must be shown to *genuinely* contribute to the prevention of illness or its early detection and arrest.

Finally, a common objective of mandating payment of practitioner services is a more equitable distribution of services and manpower. The belief is that improved purchasing power created by expanded coverage will attract practitioners to underserved areas. The opposing view is that physicians and other practitioners are attracted to locations which are desirable due to cultural opportunities, favorable climate, opportunities for professional interaction, and recreational opportunities. Practitioners cannot always go to the more desirable areas, since there is usually an oversupply and it is difficult to make a reasonable living. The real contradiction is that mandated payment, thereby generating greater purchasing power in the already oversupplied areas, will make it financially feasible for practitioners to move into

the attractive areas. Obviously, the underserved areas will not enjoy the proposed benefit. The effects of the Medicare and Medicaid programs have demonstrated this point.

Evaluation of mandated coverage legislation must take into account the probable consequences vis-a-vis the targeted objectives. The health insurance mechanism has clear limits as an instrument for remedying many of the very real problems with the health care delivery system in Virginia. Expanding coverage by legislative mandate has very serious potential for increasing the cost of insurance, raising total health care expenditures, generating unnecessary utilization, and exacerbating the maldistribution of health manpower. These effects are long-term and are much greater than the apparent immediate consequences of a small premium increase. This is why an indepth analysis of each mandated coverage proposal is necessary. Mentioning these possible negative effects is not intended to preclude further consideration of mandated benefit proposals. Rather legislators and bill proponents must anticipate such consequences.

Chapter IV

ISSUES

The purpose of this study has been to investigate whether there may be a better way of deciding on the appropriateness for state mandated coverage legislation. The decision is and should remain the responsibility of the Virginia General Assembly. Therefore, the emphasis must be on how we can improve on the quality of each decision. The previous chapters intended to lay a foundation for understanding the general trends and the impact of changes in health insurance coverage on the health care delivery system. This chapter focuses on what is problematic with the current process of reviewing legislative proposals for mandated coverage. An important aim of this chapter is to further identify deficiencies or limits in the current process, both existing and anticipated, that should be addressed in any alternatives purported to be improvements.

Problem With Current Decision-Making Process

Proposed mandated coverage bills are discussed in the appropriate House and Senate legislative committees, then voted upon in each House of the Virginia General Assembly.

One prominent concern regarding the current process is the limited amount of time devoted to a proper review in each of the legislative committees. For this reason and others there is no indepth, comprehensive evaluation of each proposed bill. The Virginia General Assembly is under extreme pressure to effectively handle the massive amounts of work they must perform each session. Mandated coverage legislation is a relatively insignificant item compared to many other more significant issues and proposed bills. Each legislative committee must apportion its time among a multitude of bills, and

predictably the more important ones are judged by degree of impact on tax revenue dollars. It appears that most of the mandated coverage bills have been successfully passed; therefore, one might expect that any evaluation mechanism would be viewed by bill proponents as an obstruction and unnecessary bureaucratic interference.

Another aspect which is partially a result of time limitations is the failure to examine the proposals according to critical questions or uniform criteria regarding cost impact, change in the distribution of services, effect on quality of care, probability of achieving proposed objectives, and so on. The debates are too often emotionally charged and one-sided given the limited input. In such an atmosphere, bill proponents are at an advantage because it is usually a one shot effort and this makes it easier to exaggerate claims and downplay pragmatic considerations, such as costs. The opponents are usually raising questions which are difficult to answer and seem to oppose postulated outcomes which are undeniably desirable, yet may be unattainable given current resources and potential costs.

Input is usually limited to proponents and insurance company lobbyists. Occasionally, medical society lobbyists enter the discussions usually depending on the nature of the proposal. Legislative committees do permit input from any interested parties, such as consumers and health planners; however, they appear to lack the awareness of the need to inject themselves into the discussions. The health planning agencies can be a valuable source of input. Often, a purpose of the proposed legislation is to remedy access and resource distribution problems. Staff of a local or state health planning agency should be able to define the extent of the problem and what is the likelihood of achieving the expected outcome. A broader range of input is desirable and necessary.

The advantage of more time and expanded input is that the long-term consequences of such decisions will be more

clearly judged. The immediate impact on premium rates is usually small and seemingly insignificant; yet, as explained in the previous chapter, the long-term consequences are usually higher prices and increased utilization. This may cause a rise in total expenditures and eventually a rise in insurance premiums. The net gain to the consumers over the long run may be then questionable. This does not mean all proposed bills should be squelched, merely that when passage of a mandated coverage bill is desirable, concurrently controls or structural changes in the system should be implemented to minimize the deleterious effects.

The process of review of proposed bills in the future must facilitate more forms of input; dedicate more time to the review process; and evaluate the proposals according to clearly defined criteria. A universal concern of most persons interviewed during the study was the prospects of increased regulation and interference by introducing such a review mechanism. On the other hand, an often expressed viewpoint is that eradication of the current non-systematic, chaotic process is worth the risk.

Interference With Free Market Forces

One objection to mandated coverage legislation is the interference with individual freedom. The belief is that the decision regarding the choice of benefits should rest with the consumer. In a competitive, free market system, the consumer has the opportunity and ability to be well informed and is able to bargain among producers to obtain the best terms of sale. In the market for health care services and insurance coverage, the consumer is not well informed, particularly as to the consequences of inaction or alternative actions. For this reason, some consideration might be given to mandating a minimum benefit package and then leave all additional coverage completely to individual selection. The National Association

of Insurance Commissioners has prepared model regulations for minimum benefits standards.

The difficulty is to define what minimum benefit package is needed. The variation in approach will depend on the perceived purpose of insurance coverage and provider's interests. One example of the complexity is maternity coverage. The elderly and single males could argue that a minimum benefit package should not include such coverage as they are being discriminated against by bearing this share of risk. However, it is in the interests of society for all mothers and children to receive proper care. To keep premiums for maternity care at a reasonable level, then the risk must be spread over a pool of persons larger than the group most likely to need or use maternity services. Otherwise, some degree of adverse selection would occur. Couples having achieved the desired family size would choose to drop such coverage.

Consumers strive for the most comprehensive protection and want to sacrifice as little resources as possible. These are always conflicting goals when searching for a definition of adequate coverage. Many insurers would welcome a mandated minimum benefit package, since it would eliminate competitors marketing "inferior" policies, such as "dread disease" policies or ten dollar-a-day hospitalization plans. The state of New York has enacted legislation prohibiting the sale of "dread disease" policies.

The insurers commonly argue against the state mandating benefits because the process of negotiation between labor unions and employers is an adequate reflection of consumer preferences and needs. There is a clear bias, since insurance companies prefer group health insurance business, and it is usually their point of reference in discussions on this matter. The Virginia General Assembly is concerned with all Virginians; and union-employer negotiations only covers approximately 247,000 workers (13.8% of employed persons in Virginia in 1974).[5]

Group hospitalization plans are sold to many more persons through non-unionized employers all over Virginia. It would be naive to assume that employee interests are the paramount concern in the selection of an employee health insurance plan. This in no way implies irresponsibility, merely that a critical criteria is premium cost. Smaller firms (as measured by number of employees) generally lack the motivation and the staff support to evaluate benefit packages versus employee needs. Unions do this simply because they possess the proper resources. Part of the insurer's concern is that mandated coverage may exceed what is demanded by non-unionized employers, and they will not be able to successfully market their plans.

State mandated benefits create problems for large, multi-state employers. These firms have plants or outlets in a variety of states with differing mandated benefits. Administration of separate benefit packages is a problem since it increases the expense and increases the inequity of benefits among employees. The result is that many such firms have opted for self-insurance due to proven cost savings. The regulatory mechanisms of Virginia have no authority over self-insured companies; consequently, the intent of mandated benefits is circumscribed. The insurance companies are concerned since this is a loss of business; though, the commercials and the Blues still have an opportunity to market their services of claims processing, reinsurance, or general administrative support to the self-insured. One tactic by these larger companies has been to fight for exemption from state mandated benefits under provisions in the ERISA legislation. Standard Oil has filed suit to gain such an exemption.[6] The federal government—largest, multi-state employer—has gained an exemption under the recently enacted Preemption Bill (HR 2931). This federal law (P.L. 95-368) preempts Federal Employees Health Benefits carriers from providing state mandated benefits

or making payments for services performed by state mandated providers if the Federal Employees Program contract does not otherwise allow benefits for these services or providers.[7] This will limit the provision of state mandated benefits in northern Virginia and other areas of Virginia with sizeable concentrations of federal employees.

Control Over Cost Escalation

Expenditures on health care have risen dramatically. These increases reflect a combination of forces: increases in price, population growth, increased utilization of medical services, and quality improvements. State mandated benefits are of some importance regarding this issue. Demand for services is a function of both supply of services and insurance coverage. The President's Council on Wage and Price Stability Staff Report (January, 1977), addressed this very point in their findings, as follows:

> "Patients demand (and hospitals supply) increasingly and use sophisticated hospital services because public and private insurance pays a growing share of the cost of care." [8]

As conceptualized in Chapter II, expansion of insurance coverage is cost-raising. Accordingly, further expansion of mandated benefits may result in discontinuance of coverage by small employers due to increased cost. If it is appropriate to expand coverage, then we must make provisions that will create some trade-off in the use of resources. The possibilities are unlimited. A simple example is a requirement that when adding an ambulatory care service to the benefit package, a financial incentive or controls be created which will limit use of interchangeable inpatient services. Interchangeable connotes substitution of an ambulatory service when it is cost effective and equally efficacious. For example, dilation and curretage performed on an inpatient basis

will not longer be covered, unless the medical necessity for hospitalization is documented.

Another example might be to stop paying psychiatrists for services which can be performed by clinical social workers; or, only pay clinical social workers located in "physician shortage" areas. In addition, control can be exercised by limiting social workers' fees to some proportion of psychiatrists' fees, possibly one-half.

To continue expanding health insurance coverage/ benefits without controls or offsetting reductions in other benefits will only further inflate health care costs.

Measuring Cost Impact

The impact of mandated benefits on premium costs and overall health care expenditures is routinely raised as a point of contention. This is a very appropriate consideration as previously stated. Yet, the argument seems to lack any real effect on the decision-making thus far.

The reason may be, as shown on the following page, that the addition to the monthly premium expense appears to be small. For instance, the estimated impact on the rates of a midwestern Blue Cross-Blue Shield plan for covering chiropractor services is $0.26 per month for a single policyholder and $0.66 per month for family (group rates). However, multiply this figure times the number of subscribers and the amount of money becomes significant. If this were to be done with crude estimates, there could be an initial cost to Blue Cross-Blue Shield subscribers in Virginia of $11,000,000 annually which will be borne by individual consumers or employers. The reader must be aware that these are only crude estimates, using cost figures from another state which may understate or overstate the cost to Blue-Shield subscribers in Virginia and does not include cost of coverage provided by commercial insurers.

SCHEDULE OF BC/BS GROUP RATE CHANGES
DUE TO STATE MANDATED COVERAGE
IN MID-WESTERN STATE

Type of Mandated Coverage	Additional Monthly Premium Expense	
	Single	Family
Chiropractor Services	$0.26	$0.66
Basic Dental Services	.13	.30
Optometrists	.01	.03
Podiatrists	.11	.27
Newborn—Ill Baby Care	—	.67
Psychologists—30 days of Inpatient Care	.29	.72
Psychologist Services Only	.01	.04
Increase Outpatient Visits from 30 to 45 Under Blue Shield	.49	1.22
Nervous, Mental, Chronic Alcoholism, and Drug Addiction Under Blue Shield Major Medical	1.60	3.52
Increase Inpatient Days from 30 to 40—Nervous, Mental, Chronic Alcoholism, and Drug Addiction Under Blue Cross	.09	.18
Chronic Alcoholism and Drug Addiction—Blue Shield	.04	.10
*Catastrophic Coverage	3.68	9.20
Physical Therapists—Outpatient	.30	.74
Physical Therapists—Inpatient	.05	.12
Well Baby Care	—	.26
Obstetrical Benefits on Single Contracts	.59	—

Source: A mid-western Blue Cross/Blue Shield Association (Annonymous per request)

*Percent of covered benefits in excess of $5,000 per individual, or $7,500 per family per contract period of 12 months with a three month carryover provision. Mental illness benefits covered up to 50% for inpatient. Outpatient visits up to 20 visits during a 12 month benefit period.

In Maryland the Economic Matters Committee of the State Legislature with the assistance of the Maryland Blue Cross and Blue Shield Plan studied the cost impact of eighteen health insurance benefits mandated over the past ten years. After reviewing this data, the Committee concluded (Appendix C):

> "It appears from the data in the Blue Cross-Blue Shield Report that the mandated coverages passed by the Legislature in the last decade may have increased the cost of health care to the health insurance policyholder without necessarily improving the quality of where a health service is added as a benefit paid by insurance, the incidence of the unnecessary utilization of that service may increase. The Committee questions the ability of the average policyholder to afford these mandated coverages when one considers that there is doubt as to whether his health care has been improved." [9]

The Maryland Blue Cross Plan calculated that the eighteen benefits increased Blue Cross subscribers' premium costs by approximately $23.5 million per year. An additional $12.5 million in premium cost would be incurred by subscribers if they elected to purchase mandated optional coverage. The effect on Blue Shield aggregate premium cost would be approximately $3 million per year (Appendix C).

The impact of mandated benefits on premium expense is more extensive than appears by the immediate net change in monthly premium expense. More importantly, the purported benefits have to be seriously considered in light of the full impact on health care expenditures.

Most of the cost of group health insurance programs (the predominant form of health insurance sold) is borne by employers. The net effect of expanding insurance coverage is to inflate the costs of doing business in Virginia.

The aforementioned are the more apparent costs. Total expenditures will be raised by increased coverage, due to predictable increasse in utilization of covered and non-covered services, some of which may be inappropriate. In the case of coverage for institutional services an expansion in capacity is likely. The capital expenditures may become significant; this is a critical factor in rising health care costs. All are long-term effects which again necessitate careful examination.

Many states have embarked on programs of deinstitutionalization of the mentally ill with emphasis on the private sector to serve their needs. Accordingly, insurance coverage and private psychiatric services have been expanded. Yet, public officials and private citizens are now questioning the efficacy and cost-effectiveness of this policy. Should mandated insurance coverage be used as a means for effecting State policy goals? At the risk of sounding redundant, it must be appreciated that changes in coverage are more far-reaching than the immediate increase in premium expense.

New Practitioners

As the concept of comprehensive health services has taken hold, there has been concommitant acceptance of the role of non-physician professionals in providing health care services. These various professionals—chiropractors, nurse midwives, nurse practitioners, psychologists, clinical social workers, physicians' assistants, and so on—have sought professional recognition through licensure and then reimbursement as an independent practitioner. Mandated coverage legislation will normally read that the practitioner can perform within their scope of licensure and is entitled to reimbursement for rendering such services by the commercial and prepayment insurance companies. In most cases, the scope of practice has no limits other than the non-physician practitioner cannot admit patients to a hospital and prescribe drugs.

The source of controversy is that insurance carriers have declined to reimburse non-physician practitioners directly as a bona-fide independent provider. Yet, the clinical social workers, psychologists, nurse practitioners, and others enjoy third-party reimbursement if they provide their services within a physician's practice. Few insurance carriers have established procedures for looking beyond a physician's claim for reimbursement as to whether the physician or non-physician practitioner provided the particular service. There is variation in procedure all over the nation. The most important feature to the insurers is that under no circumstances should a non-physician practitioner be reimbursed for a service unless it is under the supervision of a physician. The practitioners will argue that their contribution cannot be maximized until payment is made directly to them without the service being ordered or supervised by a physician. Proponents of mandated payment bills have argued for removal of this restriction on their practice with claims of improved distribution of health manpower and reduced costs.

The stated claims are worth pursuing as long as there is some certain likelihood of success. The doubt is derived from practical experience. In the past when consumers have been granted greater purchasing power, there has been little redistribution of health manpower and no dimunition in health care costs. These problems will not be remedied by free market forces, so at the least mandated payment bills have to be designed differently in the future to increase the probability of success.

The findings of researchers and insurance executives might be summarized in the following cautionary notes regarding expanded coverage of new practitioner services:

1. Practitioners are not drawn to underserved (manpower) areas, in fact find it possible to practice in over-supplied areas due to the expanded purchasing power.

2. Due to the broad scope of licensing laws, expanded coverage often allows unqualified practitioners to enter the marketplace as providers.
3. Third-party reimbursement of new practitioners on a fee-for-service basis will inflate expenditures. Fees of the non-physician will escalate over a short period using physicians as the frame of reference.
4. The availability of third-party payments will lure practitioners from the public sector into private practice. The effect may be that the "less needy" and more affluent consume a greater proportion of resources.
5. Treatment strategies will be determined more by economic considerations than by clinical principles.

Regarding item #3, Blue Cross and Blue Shield of Colorado has found in offering a new benefit which allows direct payment to psychiatric social workers that their fees have started to approach the level of psychiatrists' fees ($55.00 to $60.00 per hour).[10] These are preliminary findings. The possible undesirable effects, listed above, of mandating payment of independent, non-physician practitioners are particularly likely when initiated without limits or controls.

The federal government may have set forth an example in recent regulations under the Rural Health Clinic Services Act of 1977 (P.L. 95-210).[11] The regulations permit reimbursement for services provided by physician assistants or nurse practitioners in rural health clinics on a cost basis, not fee-for-service. Eligible sites must be located in areas underserved by physicians, as determined by the Secretary of H.E.W. Another important feature is these providers need only to have services reviewed by a physician and a physician must be routinely

available for consultation. This is a loosening of the stricter "medically necessary" model.

There are ways to assure some minimum level of quality and proficiency. One method is to tie eligibility for reimbursement to specific educational qualifications or professional certification. To facilitate this the respective professional association could develop a "directory" of qualified practitioners. Eligibility could be conditioned upon participation in an approved peer-review activity. The focus would be the appropriateness and quality of services provided.

The purpose of reviewing each of these critical issues in this chapter is to highlight the important components of the need for uniform criteria in evaluating the appropriateness of mandating additional benefits. The criteria will serve to guide an analysis regarding the likelihood of achieving the objectives stated by a bill's proponents. Also, it will sensitize those responsible for evaluation to the possible need for limits or controls. If mandated coverage legislation is expected to reach beyond the providers' interests, then every effort must be made to insure improvement of the consumers' status.

Chapter V

ALTERNATIVE REVIEW MECHANISM

There are seven alternative mechanisms to the present process of evaluating mandated coverage bills in the Virginia General Assembly that have been identified during the course of this study. Continuing with the status quo is always an alternative until it can be excluded once one of the other alternatives is believed to address the identified problems.

Summary of Problems

To set the perspective for evaluation of each alternative mechanism, the problems with the current process have been summarized below:

1. Proper amount of time is not allocated for review of proposals in the rush of the legislative session.
2. Undue pressure by special interest groups appears to preclude comprehensive, indepth analysis of all pertinent issues.
3. There is a lack of uniform criteria by which each proposal is evaluated.
4. Current review process does not facilitate wider number of input types with expertise in health planning, licensure, utilization review, and cost containment methods.

An implication of all four statements is that given the complex nature and varied consequences of each decision to mandate coverage, a different approach must be seriously considered.

Guiding Principles of Organization

Only the imagination limits the number of potential alternatives. Yet, no alternative mechanism is acceptable at any cost, merely because it addressed the four identified problems. For this reason the consultant developed five guiding principles of organization, listed below, which served as a basis for disqualifying some potential alternatives and constructing others:

1. Expansion of state government must be minimized, thus cost to taxpayer.
2. Review mechanism must not intrude on decision-making autonomy of Virginia General Assembly.
3. Placement of review mechanism within government hierarchy and membership must be predicated on avoidance of dominance by any one interest group.
4. Technical assistance in the areas of insurance and health care delivery must be available to membership of any body reviewing proposed mandated benefit legislation.
5. A more effective review process will require clearly defined and stated operating guidelines, mission statement, and evaluation criteria.

Alternatives

The eight alternatives are reviewed uniformly regarding elements, such as structure, membership, scope/function, review process, source of staff assistance, and then the advantages and disadvantages are discussed. In Appendix B, each of the alternatives are exhibited in an abbreviated fashion to facilitate easier comparison. Each element is only addressed insofar as it might deal with review of mandated coverage bills.

Alternative #1—Status Quo

Structure	—Legislative Committees in the two Houses of the Virginia General Assembly are the site of mandated coverage bill review.
Membership	—Legislators and consumers.

Scope of Activities —Reviews all proposed bills.

Review Process —Once mandated coverage bill is drafted, bill is referred from Desk of Clerk of House of Delegates to the appropriate legislative committee.

Source of Technical Assistance —Joint Legislative Audit and Review Commission and other State Agency Staff can always be called upon.

Discussion —The deficiencies of the current process have been discussed throughout this report. There should be no change in the status quo unless one of the other seven alternatives offer a demonstrable improvement.

Alternative #2—Review by State Health Coordinating Council (S.H.C.C.)

Structure —S.H.C.C. is located in the Virginia Department of Health.

Membeship —This is dictated by Federal Health Planning legislation (P.L. 93-641) as follows:

> ". . . no fewer than sixteen representatives appointed by the Governor of the State submitted to the Governor by each of the health systems agencies; each such health systems agency shall be entitled to at least representatives on the S.H.C.C.; not less than one-half shall be individuals who are consumers of health; the Governor of the State may appoint such persons (e.g., public officials and providers) . . . may not exceed forty percent of the total membership." [12]

Scope/Function —Upon request of Virginia General Assembly, S.H.C.C. would review and comment on impact of mandated benefit bill.

Review Process —The bill would be referred by Chairman of House Legislative Committee to S.H.C.C. for review. Public hearings conducted; staff of State Health Planning and Development Agency performs impact study; and full S.H.C.C. reviews findings and submits comments and/or recommendations to House Committee.

Source of Staff Support—Division of Health Planning and Resource Development provides Staff and administrative services to S.H.C.C.

Discussion —Advantages are this is already existing agency, which possesses data and has health planning expertise, and should have developed insights into health care needs in Virginia. Disadvantages are the S.H.C.C. has already a heavy workload and faces an inordinate number of complex issues. Alloting a proper time to review mandated coverage bills would be difficult. The entire health planning effort has not been entirely successful, and its future is not predictable.

Alternative #3—Bureau of Insurance Advisory Commission

Structure —The Advisory Commission would be located in the Bureau of Insurance. Members would be appointed by the Governor. There would be no compensation, but members would be reimbursed for appropriate expenses. Terms of appointment would be for three years; however, of the initial members, two would be appointed for a term of one year each and three for a term of two years each.

Membership —Eight members appointed by the Governor and three ex-officio members:

2—Consumers (one from a labor union).
2—Legislators (one from each House).
1—Chairman, Statewide Health Coordinating Council or designee.
1—Chairman of a Professional Standards Review Organization in Virginia (a physician).
1—Member from Board of Commerce (preferably member on subcommittee dealing with study of licensure needs).
3—Ex-officio, Commissioner of Insurance, Commissioner of Health and Commissioner of Mental Health.

Scope of Activities —This commission would be responsible for review and comment on *all* mandated cov-

erage bills and conduct under its own initiative analysis of health insurance coverage, impact on costs, and so on.

Review Process —Steps would be as folows:

(1) All bills must be referred by Chairman of Legislative Committees or proposals may be submitted by Insurance Commissioner who may be petitioned to do so by general public or professional groups.
(2) Public hearings.
(3) Bureau of Insurance staff conduct study.
(4) Advisory Commission deliberate on public hearings results and findings on staff.
(5) Vote on formal recommendation.

Source of Staff Support—Staff of Bureau of Insurance, Department of Health, and Department of Mental Health.

Discussion —Advantages are minimal expansion of government bureaucracy and cost is minimized; Bureau of Insurance appears to be most neutral body and best able to develop the technical expertise; this alternative provides flexibility in composing membership of advisory commission; the decisions are primarily dealing with insurance matters; and this alternative is likely to have the most support.

Disadvantages are some groups may believe Bureau of Insurance is too close to some of the concerned parties. Often, it is believed a regulator is captured by the "regulated." This is not to criticize existing staff, only recognizes this analysis must transcend consideration of current personalities.

There are a couple of controversial features of the suggested review process. It should be required that all bills are referred to the Advisory Commission for a recommendation; otherwise, a referral if optional, is likely to be perceived to be a step to kill it. Consistency will lessen this perception. Before proposals directly submitted by the general public or professional groups can be reviewed, the Insurance Commissioner must approve after being petitioned; or the Chairman of the Advisory Commission may reserve this authority.

Alternative #4—Virginia Health Care Cost Containment Commission

Structure —Stands as an independent commission created by a Joint Resolution of the Virginia General Assembly with a short life of two years.

Membership —Appointed by Governor:

Consumers
Legislators
Ex-officio, Commissioner of Health, Insurance Commissioner, and Commissioner of Mental Health

Scope of Activities —Commission would be responsible for review and comment of all mandated coverage bills and under existing "investigative powers" could study health insurance problems.

Review Process —Same as Alternative #3.

Source of Staff Support—Staff from Bureau of Insurance, Department of Health, and Department of Mental Health.

Discussion —Advantages are already existing body with mandate to study respective issues; mix of legislators and consumers in membership is believed to be desirable; and is viewed as neutral body.

Disadvantages are the short life of the commission; limited scope of activities may not justify expense of free-standing commission; and additions to membership is precluded by Joint Resolution.

Alternative #5—Virginia Health Services Cost Review Commission

Structure —Recently established by Virginia legislation as free-standing body.

Membership —Prescribed by law to be appointed by Governor, as follows:

3—Consumers
3—Health Care Administrators
1—Blue Cross/Blue Shield Representative
1—Commercial Insurance Representative
Ex-officio members, Commissioner of Health, Commissioner of Mental Health, and Insurance Commissioner.

Scope of Activities —Empowered to review hospital charges on a voluntary submission basis and provided investigative powers.

Review Process —Same as Alternative #3.

Source of Staff Support—This body is entitled to own staff, so can hire appropriate technical staff.

Discussion —Advantages are the Commission will eventually be involved in investigating hospital costs. Members on the Commission should develop valuable insights and abilities.

Disadvantages are the mandated responsibility is so complex and time-consuming that there will be little time for additional duties. Activities will be limited essentially to hospital costs.

Alternative #6—Advisory Commission Within Office of Secretary—Human Resources

Sturcture —Located in executive branch, yet serves in advisory capacity to Virginia General Assembly.

Membership —Same as Alternative #3.

Scope of Activities —Review all bills and proposals; and initiate research and evaluation studies.

Review Process —Same as Alternative #3.

Source of Technical Assistance —Staff from one of departments grouped under Human Resources (e.g., Department of Health—Division of Health Planning).

Discussion —One advantage is this one may be the most neutral site short of creating a new independent commission. However, a disadvantage is that another branch of state government, formerly not involved, will be

brought into the deliberations. Also, the Secretary's Office lacks the technical assistance support necessary within the Office's immediate staff.

Alternative #7—One Year Study Commission—Minimum Benefit Package

Structure —Free standing, located in legislative branch; similar arrangement to Virginia Health Care Containment Commission or could be a subcommittee of latter.

Membership —Nine appointees by the Governor:

2—Consumers (1 member of labor union).
1—Blue Cross/Blue Shield Representative.
1—Commercial Insurance Representative.
1—Non-Governmental Health Care Administrator.
1—Chairman, State Health Coordinating Council.
1—Legislator.
1—Chairman, Professional Standards Review Organization.

Scope of Activities —Evaluate health insurance coverage needs and identify gaps in existing coverage, preferably with a temporary moratorium on mandating any additional benefits and coverage.

Review Process —Proper study would consist of public hearings on selected subjects and staff reports, then, if appropriate, legislation would be recommended.

Source of Staff Support—State agency personal, J.L.A.R.C., and/or consultants.

Discussion —Mandated coverage proposals are at times a result of clear problems in proper coverage, rather than just the interests of providers. Proper study of the needs may address the real problems of consumers, and a minimum benefit package may lessen the stream of mandated coverage proposals to the General Assembly. This issue is currently on the agenda of the Virginia Health Care Cost Containment Review Commission. Yet, this issue deserves a higher priority; and, if it is not properly

addressed by the Cost Containment Commission, then a new group should be organized. The main disadvantage is the expense of organizing another commission.

Alternative #8—Free Standing, Mandated Coverage Review Body

Structure —It would be located in the legislative branch, yet independent to perform designated duties. The link with the Executive branch would be through appointments by the Governor.

Membership —Appointments by the Governor would be:

3—Consumers (one from a labor union and a large employer).
2—Legislators (one from each House).
1—Chairman, Statewide Health Coordinating Council or designee.
1—Chairman, a Professional Standards Review Organization in Virginia (a physician).
1—Member from Board of Commerce (preferably member on subcommittee dealing with study of licensure needs).
3—Ex-officio, Commissioner of Health, Commissioner of Mental Health, and Insurance Commissioner.

Scope of Activities —Review mandated coverage proposals and recommend action to General Assembly; initiate research and evaluation studies into related areas.

Review Process —Steps would be as follows:

(1) All bills to be referred by Chairman of Legislative Committee or proposals submitted by Insurance Commissioner who may be petitioned to do so by general public or professional groups.
(2) Conduct public hearings.
(3) Bureau of Insurance staff perform study.
(4) Advisory Commission deliberate on public hearings' results and staff analysis.
(5) Commission vote on formal recommendations to General Assembly.

Source of Technical Assistance —Hire own staff.

Discussion —The advantage of this alternative is that it would be a truly neutral body. However, for the limited scope of duties, it may seem to be an unnecessary additional commission and expense to the taxpayers.

Evaluation Criteria

Whatever the preferred alternative, there must be uniform evaluation criteria applied to each mandated benefit proposal. If one of the seven alternatives to the present process is adopted, an absolutely critical component of the implementation phase is adoption of criteria by the membership of the review body. Even if the status quo is the preferable alternative, a Chairman of a legislative committee can use the suggested criteria in guiding the discussion and review of mandated coverage bills.

The suggested criteria is presented below. Questions are listed beneath each criteria to illustrate what specifically must be analyzed in order to perform a thorough evaluation.

Unmet Need—Whether it be a mandated coverage or payment of new practitioners' services, the rationale usually is that a segment of the population does not have necessary access to medical care or suffers an unnecessary financial hardship in the purchase of such services.

1. Current geographical distribution of pertinent providers/health manpower?
2. What are other alternatives to meeting the identified need?
3. What are the findings of the State Health Planning Agency and the appropriate Health Systems Agencies?
4. How will it contribute to the quality of patient care and the health status of the populace?

5. Is this a medical or a broader social need and does it fit in with the role of health insurance?
6. Is proposed mandated benefit legislation advocated by providers or consumers? What is the consumers' attitude regarding the need for this legislation?
7. How is the service being paid for now, does it limit private health insurance subscribers' ability to gain access to needed health service, exclusive of recipients of public service programs?
8. What evidence and/or experience in other states is there to demonstrate the likelihood of achieving the stated objectives of meeting a consumer need?

Cost Impact—This must be analyzed in terms of additional premium expense to consumers and the impact on total health care expenditures.

1. What is the projected utilization of the service to be covered by the mandated benefit over the next five years?
2. What are the anticipated fees/rates for the next five years and how do they compare with alternative providers?
3. What is the estimated increase in insurance premiums over the next three to five years?
4. What is the probable magnitude of the impact on total health care expenditures?

Control Over Utilization and Costs/Fees—Given the already excessive inflation in cost of medical care, changes in coverage or payment of new practitioners must be accompanied by measures to minimize unnecessary utilization and excessive growth in costs. This chiefly pertains to payment of new practitioners.

1. How will non-physicians be reimbursed fee-for-service or costs, and which one minimizes cost?
2. How will reimbursement be negotiated?
3. What are the bases of determining eligibility for payment?
4. Document how utilization review will be performed and ways to monitor effectiveness?
5. Should reimbursement be limited to performance of limited activities or all activities permitted by licensure? (This presupposes licensure.)

Quality Assurance—Elaborate mechanisms are now being developed to monitor the quality of physicians' services, thus there is a responsibility to consumers to continue similar efforts when reimbursing new, non-physician practitioners.

1. Should non-physician practitioners be paid only when deemed "medically necessary," that is, ordered by a physician; and, how will that determination be made?
2. Will the appropriate professional organization maintain a "registry" with standards to assure high degree of clinical proficiency?
3. Is the quality of services proposed to be offered by non-physician practitioners acceptable or better than that delivered by a physician?

The legal definition of practice for non-physician practitioners is normally so vaguely and broadly defined that it provides no assurance to consumers of the quality of service and competency of practitioners.

This is not presented as an exhaustive list of criteria and corresponding questions merely a minimum or starting point. As stressed earlier, once the membership of a review body defines their mission and develops operating guidelines, other criteria may evolve.

Chapter VI

SUMMARY OF KEY FINDINGS AND CONCLUSIONS

Key Findings

A synopsis of key findings is presented below. Each finding is followed by a page number which references the page in the text of the report which addresses the subject matter in more detail.

1. Within the last five years, there has been a trend among state legislatures in the United States to mandate additional health insurance benefits and coverage. (Page 4)
2. Future trends in state mandated benefits are likely to be, as follows:
   - There is likely to be an increasing number of mandated benefit bills passed which require additional coverage as an option;
   - The number of proposals to mandate practitioners' services will grow proportionately at a higher rate than other categories;
   - The current interest in cost containment will generate renewed interest in mandating out-of-hospital care coverage; and,
   - Social activist groups will attempt to use mandated benefit legislation as a means to indirectly influence public policy on controversial social and moral issues, such as abortion and women's rights. (Page 6)
3. Factors, identified during the course of this study, that may have contributed to the passage of mandated benefit legislation at an increased rate in many States are as follows:
   - Incomplete health insurance coverage. (Page 8)

   - Expanded definition of health. (Page 10)
   - Anti-physician sentiment. (Page 15)
   - Expanded number and types of practitioners. (Page 14)
   - Changing values and expectations of society. (Page 13)
   - Pressure to reduce taxpayers' burden. (Page 17)
   - Health insurance role as a change agent. (Page 17)
4. The general effects of expanding benefits/coverage by whatever means are threefold: (a) it usually lowers the out-of-pocket costs to the consumer for use of covered services; (b) when the out-of-pocket cost is lowered, the consumer has more cash to expend on non-covered health care services; and, (c) it assures a flow of revenue to providers. The more direct results are an increase in the price and the level of utilization of covered health care services. The financial impact on consumers is increased insurance premiums and out-of-pocket expenses. In time, the rise in health expenditures will generate yet another cry for expanded coverage. Thus, the risk is that legislative intervention (e.g., mandated benefits) starts a pernicious cycle which in the long run penalizes the disadvantaged groups which proponents purport to be helping. It goes like this. Greater insurance protection results in increased expenditures, which over the long run results in the need for more insurance protection. All the while premiums are increasing, thus demanding a progressively increasing share of the consumer's disposable income. Assuming a primary purpose of insurance is in-

come protection, the consumer gains little or nothing. This is very clear with the Medicare experience. This legislation was intended to protect the elderly's social security benefits and other retirement funds. However, the result has been that increasing expenditures has made the Medicare program so expensive that co-insurance and deductibles have been expanded and so has the need for supplementary medical insurance. The end result is that the short term gains in disposable income of the elderly in the sixties have been clearly wiped out in the seventies. (Page 22)

5. Expanded insurance coverage usually causes increased usage and an enriched product or service. This does not necessarily mean people will receive better care or gain improved access to needed health care services. Achieving these improvements is not possible through singular measures as expanded coverage, rather it demands more fundamental changes in the health care delivery system and new incentives for providers. Health insurance has clear limits as an instrument for remedying many of the very real problems within the health care delivery system in Virginia. The more predictable result of mandated benefit legislation is an improved flow of revenue to providers. (Page 25)

6. The process for reviewing proposed mandated benefit bills in the future must facilitate more forms of input; dedicate more time to the review process; and evaluate the proposals according to clearly defined criteria. (Page 30)

7. In the future mandated benefit legislation should not be passed unless there are specific provisions to insure controls on utilization and providers' fees and offsetting reductions in other

benefits. In other words some existing benefit should be eliminated to preclude costly redundancy. One example might be before mandating ambulatory surgery benefits, procedures that can be performed on an ambulatory basis (e.g., dilation and curretage) would no longer be covered under inpatient benefits. Another example might be that legislation mandating direct payment to clinical social workers for *selected* services would also prohibit payment by insurance carriers to psychiatrists for these services or only in areas of Virginia without practicing psychiatrists. Otherwise, without these tradeoffs health care expenditures will be needlessly increased. (Page 34)

8. A frequent objection to mandated benefit legislation is that it interferes with individual freedoms and free market forces. However, consumers are not informed, rational buyers of insurance as they might be in the purchase of an automobile. More appropriate government intervention might be to mandate minimum benefit standards to protect consumers from "inferior" policies. In addition, larger, multi-state employers will attempt to exempt themselves from state mandated benefits through self-insurance or legal proceedings to gain exemption under ERISA legislation. (Page 30)

9. The cost impact of each piece of mandated benefit legislation usually appears to be very small since monthly premium expense may only be increased by a dollar or less; however, when multiplied by the number of subscribers, the full impact on consumer spending is more dramatic. In the state of Maryland, a study showed that the cumulative effect of mandating 18 benefits over time, had increased consumer spending by

$23.5 million per year (this included Blue Cross subscribers only and did not include consumers with commercial insurance). (Page 35)

10. There is an increasing trend to mandate payment of non-physician practitioners. The proposed advantages of this legislation is often confronted with extreme controversy. The reason is that research and experience has shown that the proponents claims are not realized without carefully designed controls or other provisions in the legislation to insure successful achievement of the objectives.

    Health care practitioners (physicians or others) are not drawn to underserved (manpower) areas by merely mandating third-party payment. There are many other social and professional factors that are equally important. In fact, practitioners may find it possible to practice in over-supplied areas due to expanded purchasing power of the populace through mandated insurance payments. The effect often can be to discourage movement of practitioners from over-served or adequately served areas to the under-served areas.

    No one has demonstrated that there is any cost savings or stabilization in the increase of costs by reimbursing non-physician practitioners in addition to physicians under the same benefit package. Rather, research has clearly demonstrated that increased coverage of services result in increased utilization, thus total health care expenditures go up. A deceiving argument is that it must save insurance companies money when the subscriber is able to go to, for example, a clinical social worker, charging $25.00, rather than a psychiatrist, charging $50.00 for psychotherapy. The flaw in the argument is

that in a system where the provider (either psychiatrists or clinical social workers) is able to influence the price and the level of utilization, each is able to encourage enough utilization to assure an adeqaute income. The outcome is that total expenditures increase for three possible reasons: (1) the utilization of psychiatrists does not significantly decrease nor does their fees; (2) in time clinical social workers' fees begin to approach the fee levels of psychiatrists; and, (3) the utilization of clinical social workers' services increase. (Page 40)

11. Expanding coverage to non-physician practitioners under the broad scope of licensing laws may allow unqualified practitioners to enter the marketplace or result in the provision of unnecessary medical services to patients. The important point is that it is irresponsible to encourage non-physician practitioners to practice independently without the forms of control that we are now only beginning to exercise over physicians. (Page 40)

12. An acceptable alternative to the current process for deliberating on proposed mandated benefit legislation in the Virginia General Assembly should meet the following qualifications:

    - Expansion of state government must be minimized, thus cost to taxpayer.
    - Review mechanism must not intrude on decisionmaking autonomy of Virginia General Assembly.
    - Placement of review mechanism within government hierarchy and membership must be predicated on avoidance of dominance by any one interest group.

- Technical assistance in the areas of insurance and health care delivery must be available to membership of any body reviewing mandated coverage proposals.
- A more effective review process will require clearly defined and stated operating guidelines, mission statement, and evaluation criteria. (Page 44)

13. In the future proposed mandated benefit legislation should be evaluated according to criteria regarding unmet need, cost impact, provisions for controlling utilization and cost/fees and mechanisms for assuring quality. (Page 54)

Conclusion

The cost of health care in Virginia today has made adequate health insurance coverage an economic necessity for every citizen. No doubt with this fact in mind the Virginia legislature has legitimately mandated certain additional benefits to be included in all health insurance policies marketed in Virginia. The insurance industry has resisted most mandated benefits; consumers appear to be apathetic; and affected providers are always strong advocates. The diverse reactions of these three groups seem to attest to how fundamental and complex the task of defining and assuring adequate coverage.

Regretfully, mandated benefit legislation is initiated with sound motives, yet it is so piecemeal that additional problems are generated and the real deficiencies are not addressed. Mandated benefit legislation is symptomatic of real problems in the health care system, such as: the free market system will not assure adequate coverage for all the privately insured; and, the consumer is an uninformed purchaser unable to make "best buy" decisions. There is a need for third party intervention to protect consumers from significant gaps in coverage that expose them to unnecessary financial risk.

I. *The General Assembly of Virginia should temporarily, if not permanently, place a moratorium on mandating additional benefits or coverage in health insurance policies. The critical need is to examine the adequacy of health insurance coverage in Virginia and then consider passage of minimum benefit standards legislation.*

   A. A moratorium on passage of mandated benefit legislation should only be removed once a comprehensive evaluation of health insurance coverage is performed and problems are identified.

   B. In the future to minimize the cost impact and assure freedom of choice for consumers, additional benefits should be mandated only as an "option."

II. *Proposals to legislatively mandate additional benefits and/or coverage of non-physician practitioner services can have such a tremendous impact on costs and quality that each must receive an exhaustive examination according to uniform evalaution criteria.*

   A. The evaluation criteria presented on pages 54-57 should be utilized in the review of any proposal to mandate additional benefits.

   B. If the time or the needed inputs cannot be facilitated in the current review process, then a more formal review mechanism should be organized. The Bureau of Insurance Advisory Commission (Alternative #3, Chapter V) is preferred.

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APPENDIX A

MATERNITY COVERAGE
MANDATED COVERAGE LEGISLATION

States	Year of Bill's Passage	Description of Coverage
California	1976	Complications of Pregnancy
Colorado	1975	Maternity Benefits
Georgia	1977	Complications of Pregnancy
Idaho	1975	Maternity Benefits
	1976	Involuntary Complications of Pregnancy
Maine	1975	Unmarried Maternity
Maryland	1975	Maternity Benefits
	1975	Unmarried Maternity
Minnesota	1973	Unmarried Maternity
Missouri	1973	Unmarried Maternity
Nevada	1977	Complications of Pregnancy
New York	1976	Maternity Coverage
Oregon	1973	Unmarried Maternity
	1977	Civil Rights
Texas	1977	Insurance Department Regulation; Coverage of pregnancy in individual health policies made optional

Source: Blue Cross and Blue Shield Associations

OUT-OF-HOSPITAL-CARE MANDATED COVERAGE LEGISLATION

States	Year of Bill's Passage	Description of Coverage
Arizona	1971	Out-of-Hospital
Connecticut	1976	Home Health Care
Florida	1977	Ambulatory Services
Maine	1977*	Home Health Care
Minnesota	1976	Ambulatory-Surgical Coverage
Missouri	1975	Ambulatory-Surgical Centers
Nevada	1975	Home Health Care
New Jersey	1966	Hospital-Related Health Care Service or Supplies
	1970	Health Care Services
New Mexico	1977*	Home Health Care
New York	1972	Home Health Agencies and Services
	1973	Home Health Care
	1975	Home Health Care
	1976	Pre-admission Testing; Ambulatory Care
	1977	Medicare Supplements
Ohio	1972	Kidney Dialysis
Oklahoma	1976	Ambulatory Surgical Centers
Utah	1976	Ambulatory Surgical Facilities
Vermont	1976	Home Health Care

* Law requires the offer of coverage for the benefit(s) identified.
Source: Blue Cross and Blue Shield Associations

CATASTROPHIC COVERAGE MANDATED COVERAGE LEGISLATION

States	Year of Bill's Passage	Description of Coverage
Arizona	1974	(repealed 1976)
Connecticut	1975*	Comprehensive Health Care
	1976	Amendment
	1977	Amendment
	1977	Amendment-Second Surgical Opinion
Hawaii	1974	Prepaid Health Care Act
Minnesota	1976	Comprehensive Health Expense Protection
Rhode Island	1974	Catastrophic Health Insurance
	1975	Plan Amendment

* Law requires the offer of coverage for the benefit(s) identified.
Source: Blue Cross and Blue Shield Associations

MISCELLANEOUS BENEFITS MANDATED COVERAGE LEGISLATION

States	Year of Bill's Passage	Description of Coverage
California	1970	Sterilization
	1974*	Employment of Physically Handicapped
Delaware	1974	Unfair Trade Practices: Age Discrimination
Illinois	1975	Rape Victims
Louisiana	1974	Nongroup Policies to Age 65
Maryland	1975	Blood Products
New York	1975	Insurance Department Regulation: Reconstructive Surgery
	1976	Pre-admission Testing
	1976	Second Surgical Opinions
	1976	Insurance Department Bulletin: Second Surgical Opinions
North Carolina	1977	Mentally and/or Physically Handicapped
Ohio	1976	Unfair Trade Practices: Discrimination of Sex or Marital Status
Wisconsin	1975	Kidney Disease and Organ Transplant

* Law requires the offer of coverage for the benefit(s) identified.

Source: Blue Cross and Blue Shield Associations

CONTINUED COVERAGE MANDATED COVERAGE LEGISLATION

States	Year of Bill's Passage	Description of Coverage
California	1971	Dependents' Coverage
	1976	Disabled Employees
	1976	Divorced Dependents
	1976	Surviving Spouse
	1977	Contract Replacement
Connecticut	1975	Extended Coverage
Florida	1974	Replacement Coverage
Idaho	1975	Disabled Individuals
Illinois	1976	Divorced Spouse
Louisiana	1977	Contract Replacement
Maryland	1977	Conversion Privilege: Divorced or Widowed Spouses
Massachusetts	1975	Laid-off Employees
Minnesota	1973	Disabled Employees
	1973	Survivor(s)
	1973	Government Hospital Services
	1974	Terminated Employees
	1975	Amendment: Terminated Employees
	1976	Amendment: Conversion Privilege
	1977	Conversion Privilege: Divorced Spouses
	1977	Conversion Privilege: Cancellation or Termination for the entire group
Missouri	1969	Conversion Privilege: Survivors
New Jersey	1976	Survivors
	1976	Amendment
New York	1971	Conversion Privilege
Ohio	1975	Conversion Privilege
Oklahoma	1975	Extended Coverage
Oregon	1977	Contract Replacement
Texas	1977	Extended Coverage: Group Coverage During Strikes

Source: Blue Cross and Blue Shield Associations

MENTAL AND/OR NERVOUS CONDITIONS MANDATED COVERAGE LEGISLATION

States	Year of Bill's Passage	Description of Coverage
California	1973*	Group Coverage
	1976	Social Workers' Services
Colorado	1976	Mental Illness Minimum Benefits
Connecticut	1974	Mental and/or Nervous Conditions
	1976	Amendment to 1974 Law
Illinois	1974	Mental Illness
	1975	Mental and/or Physical Illness
	1977*	Mental, Emotional, or Nervous Conditions
Louisiana	1975*	Mental Care
Maryland	1973	Mental Illness Minimum Benefits
	1975	Mental Benefits
	1976*	Partial Psychiatric Hospitalization
Massachusetts	1973	Mental or Nervous Conditions
Minnesota	1975	Mental or Nervous Disorders
	1975	Emotionally Disturbed Children
	1975	Outpatient Mental Health Treatment
New Hampshire	1975	Mental Care
	1976	Amendment to 1975 Law
New York	1968	Medicaid Benefits Extension
	1977*	Mental Care Coverage
North Carolina	1975	Hospitalization in Public Institutions
North Dakota	1975	Mental Illness, Alcoholism and Drug Addiction *
Ohio	1976	Hospitalization in Tax Supported Institutions
Oregon	1973	Mental Illness Minimum Benefits
Vermont	1976*	Mental Coverage
Virginia	1976	Mental Disorders
	1977*	Outpatient Psychiatric Benefits
Wisconsin	1975	Mental and Nervous Disorders

* Law requires the offer of coverage for the benefit(s) identified.

Source: Blue Cross and Blue Shield Associations

ALCOHOLISM AND/OR DRUG ABUSE MANDATED COVERAGE LEGISLATION

States	Year of Bill's Passage	Description of Coverage
Colorado	1976*	Alcoholism
Connecticut	1974	Alcoholism
	1976	Drug Overdose
	1977*	Alcoholism: Outpatient Treatment
Hawaii	1976	Alcoholism and Drug Addiction
Illinois	1973	Alcoholism
Kansas	1977*	Alcoholism
Louisiana	1974	Alcoholism
Massachusetts	1973*	Alcoholism
Minnesota	1973	Alcoholism and Drug Addiction
	1976	Alcoholism and Drug Addiction
Mississippi	1974	Alcoholism
Missouri	1977	Alcoholism
Nevada	1975	Alcoholism and Drug Addiction
New Jersey	1977	Alcoholism
North Dakota	1975	Alcoholism and Drug Addiction
Oregon	1975	Alcoholism
	1977*	Alcoholism: Individual Policies
South Dakota	1976	Alcoholism
Virginia	1977*	Alcoholism and Drug Addiction
Washington	1974	Alcoholism
Wisconsin	1971	Alcoholism
	1975	Alcoholism and Drug Abuse

* Law requires the offer of coverage for the benefit(s) identified.

Source: Blue Cross and Blue Shield Associations

PRACTITIONERS' SERVICES
MANDATED COVERAGE LEGISLATION

States	Year of Bill's Passage	Description of Coverage
Alabama	1966	Optometrists
Alaska	1976	Optometrists
Arizona	1977	Dental Services
Arkansas	1975	Licensed Health Professionals
	1975	Podiatrists
	1975	Psychologists
California	1974	Psychologists
	1976*	Orthomolecular Medicine
Connecticut	1975	Optometrists
	1975	Naturopathic Physicians
	1975	Dentistry or Dental Medicine
	1975	Psychologists
Florida	1974	Chiropractic Services
	1974	Podiatrists
	1974	Optometrists
	1976	Chiropractic Services
Indiana	1974	Dentists, Podiatrists, Osteopaths, Optometrists and Chiropractors
Kansas	1973	Optometrists, Podiatrists and Dentists
	1973	Licensed Practitioners
	1974	Psychologists
Louisiana	1974	Psychologists
	1974	Dentists
	1975	Chiropractors
Maine	1975	Psychologists
	1975	Dentists and Dental Hygienists
Maryland	1973	Psychologists
	1977	Social Workers
Massachusetts	1975	Dentists
Minnesota	1973	Chiropractors
	1974	Osteopaths, Optometrists or Chiropractors
	1976	Optometrists
	1976	Podiatrists

* Law requires the offer of coverage for the benefit(s) identified.

States	Year of Bill's Passage	Description of Coverage
Mississippi	1974	Psychologists
Nebraska	1974	Psychologists
	1975	Dental Services
Nevada	1975	Chinese Medicine
New Hampshire	1975	Oral Surgeons
New Jersey	1973	Psychologists
New Mexico	1977	Attorney General Ruling: Freedom of Choice of Practitioners
New York	1971	Psychiatrists and Psychologists
	1973	Physical Therapists
	1975	Dentists, Oral Surgeons and Doctors of Dental Surgery
	1975	Psychologists
	1977	Social Workers
North Carolina	1973	Chiropractors
	1977	Psychologists
Ohio	1973	Dentists
	1974	Psychologists
Oklahoma	1976	Podiatric and Psychological Services
Oregon	1976	Psychologists
Tennessee	1974	Dentists
	1974	Psychologists
Texas	1977	Pediatric Services
	1977	Psychologists
Utah	1975	Optometrist, Chiropractor, Chiropodist, Psychologist or Social Worker
Virginia	1977	Insurance Commissioner Order: Psychologists Optometrists Opticians
Wisconsin	1974	Chiropractors
	1974	Optometrists

Source: Blue Cross and Blue Shield Associations

DEPENDENT COVERAGE
MANDATED COVERAGE LEGISLATION

NEWBORNS

All laws require coverage of newborns from the moment of birth.

States	Year of Bill's Passage	Description of Coverage
Alaska	1975	
Arizona	1974	
Arkansas	1975	
California	1971	
Colorado	1975	
Connecticut	1974	
Delaware	1974	
Florida	1974	
	1977	Amended to include national accounts
Hawaii	1974	
Idaho	1974	
Illinois	1975	
Indiana	1976	
Kentucky	1976	
Louisiana	1973	
Maine	1976	
Massachusetts	1974	
Minnesota	1973	
Mississippi	1974	
Missouri	1974	
Nebraska	1975	
Nevada	1976	
New Hampshire	1975	
New Jersey	1975	
	1975	Amended to include children of unwed mothers

States	Year of Bill's Passage	Description of Coverage
New Mexico	1975	
	1977	Transportation of newborns and high risk pregnant women to tertiary-care facilities
New York	1977	
North Carolina	1973	
Ohio	1974	
Oklahoma	1976	
Oregon	1975	
Pennsylvania	1976	
South Carolina	1974	
South Dakota	1976	
	1977	Amended to include renewed contracts
Tennessee	1974	
Texas	1973	
Vermont	1976	
Virginia	1976	
Washington	1974	
West Virginia	1975	
Wisconsin	1975	
	1977	Insurance Department Regulation

MENTALLY AND/OR PHYSICALLY HANDICAPPED CHILDREN

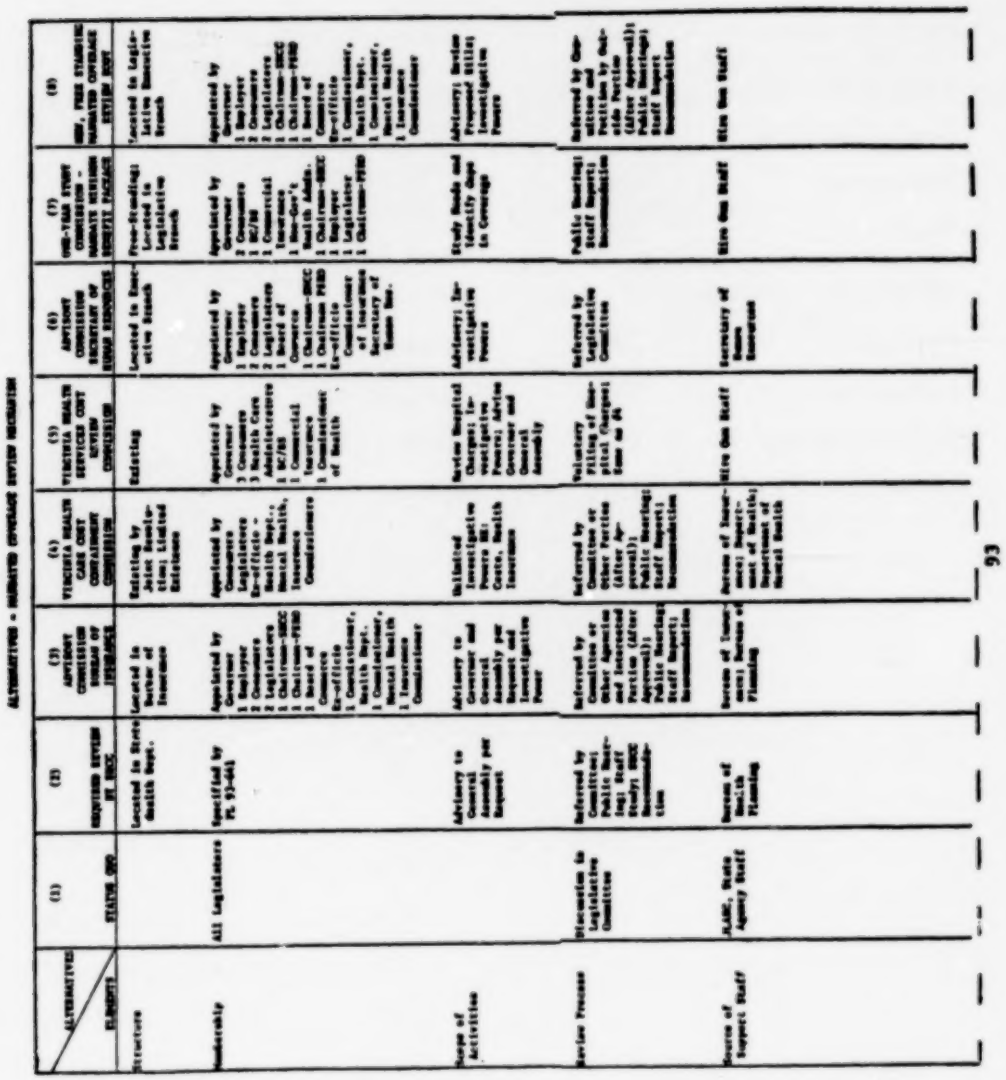
All laws require that coverage be provided for dependents who are both incapable of self-sustaining employment because of mental retardation or physical handicap, and who are chiefly dependent upon the subscriber for support.

States	Year of Bill's Passage	Description of Coverage
Arizona	1977	Age limitations may not be applied to mentally or physically handicapped dependents
Arkansas	1969 1975	
California	1971	
Connecticut	1971	
Georgia	1972	
Hawaii	1967	
Idaho	1972	
Illinois	1967	
Indiana	1969 1971	
Louisiana	1972 1974	
Maryland	1977	
Massachusetts	1956	
Michigan	1966	
Minnesota	1969	
New Hampshire	1969	
New Jersey	1966	
New Mexico	1969	
New York	1965	
North Carolina	1969 1971 1973 1977	

States	Year of Bill's Passage	Description of Coverage
Ohio	1971	
Pennsylvania	1968	
South Carolina	1970	
Tennessee	1969	
Washington	1969	
OTHERS		
California	1976	Spouses
Louisiana	1974	Students
Massachusetts	1975	Adopted Children
Nebraska	1976	Students

Source: Blue Cross and Blue Shield Associations

APPENDIX B



BEST AVAILABLE COPY

APPENDIX C

ATTACHMENT A
(Maryland)

EFFECT OF MANDATED COVERAGES ON HEALTH INSURANCE PREMIUMS

The Economic Matters Committee notes that the General Assembly in the last decade has passed legislation mandating coverage of 18 different health insurance benefits by nonprofit health service plans. The Committee finds in every legislative Session additional bills to mandate insurance coverage for additional services. The question naturally arises as to what effect these mandated coverages have on the premiums paid by the health insured.

The Committee investigated this issue during the summer and held a hearing on HB 1185, which would mandate insurance coverage for the services of nurses and nurse mid-wives. The Committee requested Blue Cross and Blue Shield of Maryland to study and make a report to the Committee on the cost for the mandated coverages passed by the Legislature in the last decade. Blue Cross and Blue Shield reported to the Committee on October 18, 1977, and a copy of the report is enclosed. It appears from the data in the Blue Cross and Blue Shield Report that the mandated coverages passed by the Legislature in the last decade may have increased the cost of health care to the health insurance policyholder without necessarily improving the quality of where a health service is added as a benefit paid by insurance, the incidence of the unnecessary utilization of that service may increase. The Committee questions the ability of the average policyholder to afford these mandated coverages when one considers that there is doubt as to whether his health care has been improved.

The total aggregate cost of all programs mandated by legislation is approximately $39 million, of which $12.5

million would be incurred by Blue Cross subscribers if they elected to purchase the coverage which Blue Cross is required to offer on an optional basis.

The Committee concludes that it is not certain that mandating health insurance benefits improves the quality of health care or reduces health costs by offering a choice to the policyholder. The committee notes that in fact health care may not have improved while health costs may have increased because of mandated coverages. The committee concludes that more information is needed on this subject and that all legislation attempting to expand the categories of mandated health insurance benefits should be examined in this light.

The Committee received testimony at the hearing on HB 1185, that at present there are no legal definitions of the occupations of Nurse Practitioner, Nurse Midwife, or Nurse Anesthetist.

Independent of the merit of this bill, the Committee recommends that no action be taken on HB 1185 until the appropriate State department issues rules and regulations defining the occupation and duties of a Nurse Practitioner, Nurse Midwife, and Nurse Anesthetist.

Exhibit D

October 18, 1977

MEMORANDUM

To: Honorable John W. Wolfgang

From: Kenneth Masters and F. M. Gloth, Jr.

Subject: Benefits Mandated by the General Assembly

The attached document lists benefits mandated by the General Assembly for nonprofit health service plans. This document gives a brief description of each of the 18 benefits that have been mandated during past years, as well as the cost of such benefits per month per corporate membership.

Based on the attached rate increments and on the estimate of the number of members affected by each of the mandated benefits, the total maximum cost to Blue Cross subscribers would be about $23.5 million per year. An additional $12.5 million in cost would be incurred by Blue Cross subscribers if they elected to purchase the coverage which Blue Cross is required to offer on an optional basis.

The Blue Shield cost for mandated benefits would be about $3 million per year.

The total aggregate cost of all programs mandated by legislation would be approximately $39 million.

If you have any questions concerning the above or the attached document, we will try to answer them for you.

ECONOMIC MATTERS COMMITTEE EFFECT

BENEFITS MANDATED BY THE GENERAL ASSEMBLY

1. *Mental and Nervous (Inpatient) (Sec. 354C)*

   This section requires that all of our policies include benefits for expenses arising from acute mental illnesses and emotional disorders which are subject to significant improvement through short-term therapy. Minimum benefits for inpatient confinement at a hospital must cover at least 30 days in any calendar year or benefit period.

   Impact is on Blue Cross. $.85

2. *Mental and Nervous (Major Medical) (Sec. 354D)*

   The second half of this section requires the provision of a Major Medical mental and nervous benefit which must be at least 50% of the benefits which the policy provides for other type illnesses.

   Primary impact is on Blue Cross. $.70

3. *Blood Products (Sec. 354E)*

   This section prohibits Blue Cross from excluding payments for blood products which would otherwise be covered. It does not apply to whole blood or concentrated red blood cells.

   Impact is on Blue Cross. $.07

4. *Maternity Hospitalization (Sec. 354F)*

   This section mandates the provision of the same benefit for maternity hospitalization as for any other covered illness if the original policy provided some hospitalization benefits for normal pregnancy. Section

does not require Blue Cross to provide or offer maternity benefits in the first instance in any policy.

Impact is on Blue Cross.
If maternity is provided. $.95

5. *Maternity Benefits/Full Coverage (Sec. 354G)*

   This section mandates the provision of maternity benefits to all group members and their dependents regardless of marital status. These benefits must be identical to the benefits, if any, provided in the basic group contract. Benefits included are pregnancy, childbirth, disability, and medical surgical care.

   Impact on both Corporations.

Blue Cross	$.11
Blue Shield	$.05

6. *Maternity Benefits/Full Coverage/Individuals (Sec. 354H)*

   This section requires Blue Cross and Blue Shield to offer maternity benefits to individuals regardless of marital status.

   Impact is on both Corporations.

Blue Cross	$.16
Blue Shield	$.12

7. *Alcoholic Rehab. (Sec. 354I)*

   This section requires Blue Cross in all group contracts issued after July 1, 1976 to offer benefits for alcoholic rehabilitation programs licensed by the Department of Health and Mental Hygiene. Minimum benefits required are not less than 30 days or partial days of inpatient care in any period of 12 consecutive months. Two outpatient visits are deemed equivalent to one day's care.

   Impact is on Blue Cross. If offered $.75

8. *Psychiatric Day Care (Sec. 354J)*

This section requires offering benefits for partial hospitalization for psychiatric care to all groups with over 25 members. Effective date was January 1, 1977. "Partial hospitalization" is defined to include treatment at a hospital, psychiatric day care center or a community mental health facility.

Impact is on Blue Cross. If offered $.20

9. *Social Worker (354K)*

This section mandates provision of benefits for services within the scope of practice of a duly licensed social worker whether those services are performed by a medical doctor or a social worker so long as the patient is referred to the social worker by the physician and so long as the original policy provides coverage for activities which are within the scope of a licensed certified social worker. Effective date is January 1, 1978.

Impact is on both Corporations.

Blue Cross	$.06
Blue Shield (limited to Outpatient Psychiatric Endorsement only)	$.02

10. *Home Health Care (Art. 48A Sec. 470J)*

This bill requires that after July 1, 1977 Plan claim offer coverage for home health care. "Home Health Care" is defined to plan the continued care and treatment of the insured if he would otherwise have had to remain in an institution and if the plan of treatment is established and developed in writing by a physician. Minimum coverage of at least 40 home care visits in any calendar year or continuous 12 month period is required. Up to four hours of

home health care services are to be considered as one home care visit.

Impact is on Blue Cross. No cost determinable

11. *Podiatrists (Sec. 354(a))*

This section requires that nonprofit health service plans in Maryland provide benefits for those services legally rendered by podiatrists that would be covered if rendered by doctors of medicine.

Impact is on both Corporations.

Blue Shield	$.10
Blue Cross	$.02

12. *Optometrists (Sec. 354(a))*

This section requires that nonprofit health service plans in Maryland provide benefits for those services legally rendered by optometrists that would be covered if rendered by doctors of medicine.

Impact is on both Corporations.

Blue Cross	$.02
Blue Shield	$.02

13. *Chiropractors (Sec. 354(a))*

This section requires that nonprofit health service plans in Maryland provide benefits for those services legally rendered by chiropractors that would be covered if rendered by doctors of medicine.

Impact is on both Corporations.

Blue Shield	$.02
Blue Cross Not determinable (i.e. less than $.009)	

14. *Psychologists (Sec. 354(a))*

This section requires that nonprofit health service plans in Maryland provide benefits for those services

legally rendered by psychologists that would be covered if rendered by doctors of medicine.

Impact is on both Corporations.

Blue Shield	$.04
Blue Cross	$.01

15. *Handicapped Children (Sec. 354(a-1))*

This section requires that any unmarried child who at the time of reaching the limiting age is incapable of self-support due to a physical or mental incapacity and who is covered under a policy as a dependent must remain covered as long as the incapacity continues or until the coverage of the parent etc. is terminated.

Impact is on both Corporations.

Blue Cross	$.05
Blue Shield	$.02

16. *Conversion Rights (Sec. 354J)*

This section requires that in all group contracts which have conversion privileges, a covered dependent spouse be offered the same conversion rights in the event the coverage ceases due to death or termination of the marriage.

Impact on both Corporations.

Blue Cross	$.02
Blue Shield	$.01

17. *Female Cancer Exam (Art. 43 Sec. 556F)*

This section requires that all female hospital inpatients over 18 be given a Pap-Smear test unless countermanded by the attending physician or unless it was performed within a year of admission. The patient at all times may refuse the test.

Primary impact is on Blue Cross	$1.50

18. *State Hospitals (Sec. 354A)*

This section requires Blue Cross to provide benefits for covered services rendered in a state hospital.

Impact is on Blue Cross.	$.14

Footnote: All figures are estimated cost per month per composite membership, based on 1.5 million members.

Membership of Blue Cross Plans
December 31, 1978
(Continued)

PLAN	REGULAR		COMPLEMENTARY		TOTAL	PER CENT OF PLAN AREA POPULATION ENROLLED**
	GROUP*	NONGROUP	GROUP	NONGROUP		
VA, RICHMOND	1,229,969	107,784	28,662	65,023	1,431,438	41.2
VA, ROANOKE	294,662	43,465	4,894	29,043	372,064	39.2
WA, SEATTLE	659,251	45,200	11,000	31,742	747,193	18.7
WV, CHARLESTON	213,371	38,959	7,097	23,767	283,194	27.8
WV, PARKERSBURG	47,284	2,816	1,322	4,159	55,581	45.8
WV, WHEELING	112,231	9,704	4,953	10,238	137,126	24.6
WI, MILWAUKEE	1,252,122	47,739	64,104	109,389	1,473,354	31.2
WY, CHEYENNE	92,922	21,088	497	7,977	122,484	28.7
PR, SAN JUAN	292,515	6,586	—	1,404	300,505	9.5
HEALTH SERVICE, INC.‡	20,505	138	—	—	20,643	—
TOTAL UNITED STATES	68,196,294	6,161,675	2,923,262	5,973,370	83,256,601	37.6

Canada and Jamaica

ALTA., EDMONTON	425,629	390,917	—	—	816,546	41.1
MAN, WINNIPEG@						
N.B., MONCTON	405,564	80,836	—	—	486,400	21.7
ONT., DON MILLS	2,369,933	487,754	—	—	2,857,687	33.4
QUE., MONTREAL	693,323	70,384	—	—	763,707	12.1
TOTAL CANADA	3,894,449	1,029,891	—	—	4,924,340	25.8
JAMAICA, KINGSTON	76,131	2,164	—	—	78,295	3.6
TOTAL BLUE CROSS PLANS	72,168,874	7,193,730	2,923,262	5,973,370	88,259,236	36.4

* Includes enrollment for Federal Employees Health Benefits Program.
** United States and Canada population figures taken from *Sales and Marketing Management*, "Survey of Buying Power," (July 1978) and projected to December, 1978.
Population of Puerto Rico taken from the *Puerto Rico Planning Board*, "Socio-Economic Statistics, Fiscal Years 1940, 1950, 1960-1977" and projected to December, 1978.
Population of Jamaica taken from *U.S. Bureau of the Census*, "County Demographic Profile: Jamaica 1977" and projected to December, 1978.
‡ A stock insurance company wholly owned by the Blue Cross Association which assists in the enrollment and servicing of national accounts.
@ December 31, 1978 enrollment report was not received prior to publication.

EXHIBIT 20

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Blue Cross Plan Financial Data
January 1, 1978 to December 31, 1978
(Continued)

PLAN	TOTAL ASSETS	TOTAL LIABILITIES	RESERVES	NET*** SUBSCRIPTION INCOME	TOTAL*** INCOME	CLAIMS*** EXPENSE	ADMINISTRATIVE*** EXPENSE	NET*** INCOME	% OF NET*** SUBSCRIPTION INCOME	
									CLAIMS EXPENSE	ADMIN. EXPENSE
NE, OMAHA**	85,956,000	29,910,000	36,046,000	124,136,000	126,552,000	105,484,000	8,031,000	13,037,000	85.0	6.5
NH, CONCORD**	50,520,000	31,498,000	19,022,000	138,068,000	141,022,000	124,230,000	9,690,000	7,102,000	90.0	7.0
NJ, NEWARK	265,650,000	208,933,000	56,717,000	616,189,000	627,289,000	575,592,000	22,320,000	29,377,000	93.4	3.6
NM, ALBUQUERQUE**	21,005,000	11,543,000	9,462,000	47,575,000	48,684,000	42,493,000	3,842,000	2,349,000	89.3	8.1
NY, ALBANY	32,770,000	28,725,000	4,045,000	113,154,000	114,276,000	109,963,000	6,684,000	—2,371,000	97.2	5.9
NY, BUFFALO@	48,548,000	30,883,000	17,665,000	145,836,000	148,164,000	135,063,000	7,987,000	5,114,000	92.6	5.5
NY, NEW YORK**	471,507,000	390,367,000	81,140,000	1,412,233,000	1,419,421,000	1,268,233,000	106,649,000	44,539,000	89.8	7.6
NY, ROCHESTER	65,770,000	39,922,000	25,848,000	134,765,000	137,885,000	119,681,000	4,499,000	13,705,000	88.8	3.3
NY, SYRACUSE	35,244,000	29,561,000	5,663,000	78,719,000	79,561,000	76,174,000	3,991,000	— 604,000	96.8	5.1
NY, UTICA	15,423,000	10,182,000	5,241,000	34,246,000	34,962,000	33,035,000	1,373,000	554,000	96.5	4.0
NY, WATERTOWN	2,679,000	1,687,000	992,000	5,148,000	5,304,000	4,964,000	251,000	89,000	96.4	4.9
NC, DURHAM**	202,222,000	110,367,000	91,855,000	386,435,000	397,656,000	355,937,000	22,321,000	19,398,000	92.1	5.8
ND, FARGO	29,478,000	14,240,000	15,238,000	64,812,000	66,130,000	57,277,000	3,162,000	5,691,000	88.4	4.9
OH, CINCINNATI	233,533,000	114,936,000	118,597,000	451,745,000	463,511,000	412,794,000	18,102,000	32,615,000	91.4	4.0
OH, CLEVELAND	157,413,000	107,531,000	49,882,000	363,408,000	365,097,000	343,666,000	16,522,000	4,909,000	94.6	4.6
OH, COLUMBUS	69,707,000	44,618,000	25,089,000	121,063,000	123,457,000	107,236,000	5,518,000	10,703,000	88.6	4.6
OH, TOLEDO	80,443,000	47,440,000	33,003,000	152,267,000	155,875,000	136,061,000	5,970,000	13,844,000	89.4	3.9
OK, TULSA**	77,323,000	50,146,000	27,177,000	155,168,000	158,242,000	140,741,000	11,760,000	5,741,000	90.7	7.6
OR, PORTLAND*	78,760,000	50,846,000	27,914,000	160,938,000	164,272,000	143,708,000	12,499,000	8,065,000	89.3	7.8
PA, ALLENTOWN	33,468,000	15,196,000	18,272,000	59,221,000	60,824,000	54,499,000	2,462,000	3,863,000	92.0	4.2
PA, HARRISBURG	97,632,000	59,557,000	38,075,000	154,390,000	159,434,000	144,486,000	5,767,000	9,181,000	93.6	3.7
PA, PHILADELPHIA	215,605,000	127,612,000	87,993,000	426,150,000	437,924,000	383,074,000	15,033,000	39,817,000	89.9	3.5
PA, PITTSBURGH	244,504,000	160,732,000	83,772,000	502,029,000	509,944,000	470,346,000	17,884,000	21,714,000	93.7	3.6
PA, WILKES-BARRE	51,294,000	31,826,000	19,468,000	105,844,000	107,969,000	96,610,000	3,126,000	8,253,000	91.3	3.0
RI, PROVIDENCE	48,413,000	33,218,000	15,195,000	129,275,000	131,138,000	113,036,000	4,830,000	13,272,000	87.4	3.7
SC, COLUMBIA**	88,115,000	49,091,000	39,024,000	183,512,000	186,321,000	163,935,000	10,460,000	11,926,000	89.3	5.7
TN, CHATTANOOGA**	186,612,000	98,012,000	88,600,000	265,408,000	274,440,000	249,745,000	15,295,000	9,400,000	94.1	5.8
TN, MEMPHIS**	28,382,000	19,691,000	8,691,000	60,946,000	61,527,000	54,018,000	4,172,000	3,337,000	88.6	6.9
TX, DALLAS*	214,506,000	152,239,000	62,267,000	487,198,000	498,997,000	464,532,000	28,562,000	5,903,000	95.4	5.9
UT, SALT LAKE CITY	14,334,000	11,112,000	3,222,000	49,313,000	49,761,000	45,830,000	2,362,000	1,569,000	92.9	4.8

* A Blue Cross only Plan; includes Medical/Surgical data.
** A Blue Cross and Blue Shield Plan; the Plan reports identical financial data to the Blue Shield Association.
*** Includes underwritten business only.
@ The Jamestown, New York Plan merged with the Buffalo, New York Plan during the second quarter 1978.

Membership of Blue Shield Plans
December 31, 1978
(Continued)

PLAN	TOTAL GROUP*	TOTAL NONGROUP	TOTAL REGULAR BUSINESS	TOTAL FISCAL ARRANGEMENTS●	TOTAL REGULAR BUSINESS & BUSINESS UNDER FISCAL ARRANGEMENTS●●	PER CENT OF PLAN AREA POPULATION ENROLLED**	TOTAL MEDICARE COMPLEMENTARY COVERAGE	TOTAL REGULAR BUSINESS	TOTAL FISCAL ARRANGEMENTS●	TOTAL REGULAR BUSINESS & BUSINESS UNDER FISCAL ARRANGEMENTS●●	PER CENT OF PLAN AREA POPULATION ENROLLED**
WA, WENATCHEE	18,227	1,777	23,498	8,241	28,245	45.48	3,494	23,498	8,241	28,245	45.48
WV, CHARLESTON	201,894	38,773	271,513	—	271,513	27.33	30,846	271,513	—	271,513	27.33
WV, CLARKSBURG	12,902	4,088	22,837	—	22,837	13.29	5,847	22,837	—	22,837	13.29
WV, MORGANTOWN	6,737	4,766	14,114	—	14,114	14.14	2,811	14,114	—	14,114	14.14
WV, PARKERSBURG	45,903	2,817	54,198	—	54,198	38.06	5,478	54,198	—	54,198	38.06
WV, WHEELING	104,538	9,606	129,335	—	129,335	27.16	15,191	129,335	—	129,335	27.16
WI, MADISON	426,333	26,554	497,835	731,061	1,183,968	25.09(d)	44,948	497,835	731,061	1,183,968	25.09(d)
WI, MILWAUKEE	1,134,691	40,873	1,350,694	120,337	1,396,466	29.38	169,130	1,350,694	120,337	1,396,466	29.38
WY, CHEYENNE	91,022	20,969	120,465	—	120,465	28.18	8,474	120,465	—	120,465	28.18
PR, SAN JUAN	303,301	25,961	340,288	145,454	474,716	14.95	11,026	340,288	145,454	474,716	14.95
MEDICAL INDEMNITY OF AMERICA‡	125,563	40	125,603	—	125,603	—	—	125,603	—	125,603	—
TOTAL	56,414,731	5,785,241	70,127,522	19,699,102	84,010,022	38.57	7,927,550	70,127,522	19,699,102	84,010,022	38.57

*Includes enrollment for Federal Employees Health Benefits Program.
**Population figure taken from *Sales and Marketing Management*, "Survey of Buying Power," (July 1978) and projected to December, 1978.
●Medicare Part B, non-underwritten Medicaid, CHAMPUS and other welfare.
●●This total has been adjusted to eliminate the double counting of enrollees under Medicare Complementary and Medicare Part B.

‡ A stock insurance company wholly owned by the Blue Shield Association which assists in enrollment and servicing of national accounts.
(d) Includes CHAMPUS in Arkansas, Illinois, Iowa, Kansas, Minnesota, Missouri, North Dakota, Oklahoma and South Dakota; population figure is Wisconsin only.

Affiliated Plans

Affiliated Plans: Vancouver, B.C.; London, England; Moncton, N.B.; Regina, Saskatchewan; Saskatoon, Saskatchewan.

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EXHIBIT 22

NATIONWIDE ADDITIONAL ANNUAL PREMIUM COST OF MANDATED BENEFITS

(Based on Colorado Experience of Blue Cross-Blue Shield)

A) Additional premium cost per individual employee for 16 mandated benefits = $91.80

B) Number of individual employees nationwide with group hospital coverage = 55,015,000

C) Nationwide additional premium cost of mandated benefits (AxB) = $5,050,377,000

EXHIBIT 23

NATIONWIDE ADDITIONAL ANNUAL PREMIUM COST OF MANDATED BENEFITS

Maryland Experience of Blue Cross-Blue Shield

A) Additional premium cost for hospital coverage = $23,500,000

B) Number of covered persons = 1,500,000

C) Additional premium cost for hospital coverage per covered person (A÷B) = $15.67

D) Additional premium cost for medical coverage = $3,000,000

E) Additional premium cost for medical coverage per covered person (D÷B) = $2.00

Nationwide Projection

F) Number of persons nationwide with group hospital coverage = 135,942,000

G) Nationwide additional premium cost of mandated benefits for group hospital coverage (CxF) = $2,130,211,000

H) Number of persons nationwide with group medical coverage = 129,308,000

I) Nationwide additional premium costs of mandated benefits for group medical coverage (ExH) = $258,616,000

J) Nationwide additional premium cost of mandated benefits (G+I) = $2,388,827,000

EXHIBIT 24

METROPOLITAN LIFE INSURANCE
"Administrative Services Only" ("ASO") Contracts

Year	Number of New ASO Contracts Issued	Total Claims*
1972	2	8,537,000
1973	1	1,207,000
1974	1	15,288,000
1975	3	2,517,000
1976	8	85,796,000
1977	9	54,213,000
1978	9	25,542,000
1979	18	35,624,000
Total	51	228,724,000

* These figures represent total claims paid by the particular companies involved for the period October, 1978 through September, 1979.

EXHIBIT 25

THE COMMONWEALTH OF MASSACHUSETTS

GENERAL COURT

JOINT COMMITTEE ON INSURANCE

ADVANCES IN HEALTH INSURANCE IN MASSACHUSETTS

SEN. DANIEL J. FOLEY
SENATE CHAIRMAN

REP. RAYMOND M. LAFONTAINE
HOUSE CHAIRMAN

AUGUST 1974

[SEAL]

THE COMMONWEALTH OF MASSACHUSETTS
JOINT COMMITTEE ON INSURANCE
GENERAL COURT OF MASSACHUSETTS
STATE HOUSE, BOSTON

ANTHONY J. BURKE
RESEARCH DIRECTOR

DANIEL J. FOLEY
SENATE CHAIRMAN

RAYMOND M. LAFONTAINE
HOUSE CHAIRMAN

August 1974

The possibility of National Health Insurance has been increasing in recent years, with almost everyone expecting its implementation soon. However, our committee felt the need to act on some grave problem areas since years were passing without any policy emerging from Washington.

In 1973 two major pieces of health legislation were passed, providing in-patient and out-patient health coverage for mental illness and alcoholism. This year we passed a bill to provide for accident and sickness policies to cover newborn infants from the moment of birth and for premature birth and birth defects.

As a result of the passage of these measures, we have received many requests for copies of our laws with background data. We felt that by compiling the information we had, it could greatly assist other states who are considering these aspects of health insurance.

We hope you will find this material useful.

Sincerely,

/s/ Daniel J. Foley
DANIEL J. FOLEY
State Chairman

/s/ Raymond M. LaFontaine
RAYMOND M. LAFONTAINE
House Chairman

MEMBERS OF THE JOINT COMMITTEE ON INSURANCE

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SENATE CHAIRMAN

REPRESENTATIVE RAYMOND M. LaFONTAINE,
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PART ONE

MENTAL HEALTH INSURANCE

MENTAL HEALTH INSURANCE: WHO NEEDS IT?

There is a lingering myth that workers enjoy better health than other groups of population, or as put by Michael Harrington in *The Other America* that ". . . As far as emotional disturbance and mental disease go, the poor are noble savages and the rich are the prime victims of tension and conflict." If this were indeed true, a discussion of broadening insurance coverage as provided in Chapter 1174 of the Acts of 1973, for mental illness would have only limited relevance. There would be a thin market for this benefit. The truth is almost the exact opposite. Harrington cites the Yale studies by Hollingshead and Redlich which showed that the poor of New Haven had three times the rate of psychiatric illness as the other classes; and that the organized worker had a higher rate of mental illness than the rich and the executive professional classes.

The UAW reports that their studies of the needs of their members and families corroborate the findings of the Yale group and other investigators. Those needing mental health insurance the most, the workers, have the least ability to pay for mental health services.

Even more importantly though, there must be a new awareness among people that in today's pressured packed, rat raced society, no one group of the population is immune to mental sickness. Man is an imperfect being and at various points in life may be in need of care of one sort or another. The sooner this view point is accepted the sooner people will come to realize the need to be guarded against costly treatment for mental illness. The coverage in Chapter 1174 safeguards the people of Massachusetts, young and old, rich and poor, against the

burdensome costs of professional mental health services and care.

THE TREND TOWARDS COMMUNITY BASED CARE

Many are now aware that this state is engaged in an enormous revolution in the care of the mentally ill. For almost two centuries the mentally ill were dumped in massive human warehouses; out of sight and out of mind. As a number of studies have pointed out over the years, it was the working person who received the short end of the stick in this disgraceful abandonment of people whose only "crime" was that they had broken temporarily under the stresses of living. For the working persons and their families, there was no opportunity for private psychiatric treatment, or even community psychiatric care, which might have prevented a more serious illness. The first stop, and frequently the last stop for the worker, was a custodial state institution. The tragic price of this neglect can no longer be tolerated.

Institutional care, for many afflicted with mental illness is obsolete, and in many cases very damaging. In years before, the thinking was that by putting people in a totally new environment (such as an isolated mental hospital), you could save them from the things that made them sick. But as time progressed there was an increasing recognition that continuous hospitalization is frequently an anti-treatment device, making it all the more difficult for the mental patient to resume his/her duties in society. People began to realize that the state mental hospitals were polarizing the population into "sick" and "well". The mental hospitals were seen not as places for treatment but dumping grounds, that were too large and too impersonal.

In this new era, it has been demonstrated that the mental patient frequently does his/her best when he/she is vertically moving about, engaging in group activities,

working in industrial therapy and gradually re-adjusting to his/her real environment. Out-patient care given at a local community mental health center, in many cases, enables the mentally ill to receive adequate treatment without costly institutionalization. But since out-patient care is presently insuring only 1% of the people of this commonwealth, community mental health centers must be publicly supported, costing Massachusetts taxpayers millions of dollars annually. By making mental health coverage mandatory, Massachusetts can continue the thrust toward community based care. This will not only increase the availability for treatment in privately run mental health centers but save the taxpayers money as well.

MENTAL ILLNESS IS INSURABLE AT A REASONABLE COST

There is a widespread belief that mental health insurance plans such as Chapter 1174, cause premium rates to skyrocket. This belief though, is false, as facts show.

Massachusetts Blue Cross is covering mental illness at an annual cost of $9.00 for individuals and $17.00 for a family. This cost is less than 2% of total Blue Cross coverage which is now about $700.00 per year. This coverage is available in a ambulatory plan, but is restricted to large groups who carry master medical insurance.

The Health Insurance Plan of Greater New York has established monthly premiums for mental health services of $.90 for an individual, $1.80 for a family of two, and $2.70 for family of three or more. This averages about $7.50 per person per year when the distribution of family size is considered.[1]

Six million federal employees are covered for mental health services on an 80%, $100.00 deductible basis, with an overall maximum of $50,000.

[1] Fink, R. "Financing Out-Patient Mental Health Care Through Psychiatric Insurance," Mental Hygiene, April, 1971 Vol. 55 No. 2.

The United Auto Workers health insurance plan which covers three million people and the Kaiser-Permanente Plan on the West Coast, with over one million subscribers, have coverage similar to that in Chapter 1174.

If mental illness is uninsurable, why are so many workers now covered? The reply may be that mental illness is insurable at a reasonable cost only when included in a large group policy. It is therefore felt rates for non-group subscribers would become exorbitant thus making any non-group health insurance policy offered in this state out of the reaches of the non-group consumer who is often on a limited or fixed income and in many cases barely able to afford any coverage. Massachusetts Blue Cross states that the "rate increase for the majority of non-group subscribers in the Commonwealth of approximately $1.15 per month for an individual and $1.70 per month for a family membership. Other non-group contract holders would have an increase in rates varying as to the type of contract held."[2] This increased premium is not much more than the amount now paid by many groups.

Yet in order for the cost to be reasonable, insurance for mental illness must be made a mandatory feature on all policies sold in the state. Otherwise this type of coverage would be extremely expensive to small group subscribers and especially burdensome to non-group subscribers. An optional offer to cover mental illness is contrary to the most basic principle of insurance—that of "risk sharing".

MENTAL HEALTH INSURANCE IS NOT ABUSED

The major worry of the insurance industry with regard to mental health insurance is that wider coverage for mental illness will lead to tremendous overutilization

[2] Memorandum to Representative Raymond LaFontaine, June 19, 1973, from Massachusetts Blue Cross.

of services. The industry boasts that it is persuaded by cold facts but actually seems governed by hysterical fears. In other words, we are a nation of hypochondriacs—people who use every device to catch schizophrenia so that they can milk the insurance companies.

What are the actual facts? In reality, practically every study of mental health benefits has pointed to underutilization—people don't enjoy being institutionalized, or going to psychiatrists and being treated for mental illness.[3]

The Health Insurance Plan of Greater New York analyzed 60,000 subscribers in the Jamaica Medical Group. The subscribers were provided out-patient and in-patient psychiatric treatments—with no upper limit to the number of services and no cost to the patient.

Over a three year period, the annual utilization for psychiatric consultation was 11.4 per 1,000 or 1.1%. For psychiatric consultation with at least one visit, the rate was 8.3 per 1,000 or .8% During the period 949 patients were accepted for treatment and 16,264 Mental Health services were provided. Of these services, 88% were individual services to patients alone, or to patients with members of their families, 11% were group therapy services, and 1% were psychological testing.

Group Health Insurance of New York City offered out-patient psychiatric coverage to 76,000 subscribers over a 36 month period. Of the relatively small 1% of the sample who availed themselves to the coverage, one half admitted that they had psychiatric symptoms for two years or more, yet they were reluctant to seek treatment. Furthermore, only 1% of those who sought treatment were rejected on grounds of "no need for treatment."

Retail Clerks Local 770, in Los Angeles offers to its more than 50,000 members 111 days a year of in-hospital

[3] Fink, R. "Financing Out-Patient Mental Health Care through Psychiatric Insurance" *Mental Hygiene* April, 1967, Vol. 55, No. 2.

psychiatric care, plus unlimited out-patient services, including group therapy and a broad range of services for the children of workers. From the inception of this plan in 1959, the problem has been underutilization by the membership. During the first three years of operation, only about 1% of those covered sought treatment; an aggressive campaign by the medical staff has lifted the rate to about 3% in recent years.[4]

This data indicates that those insured for mental illness do not abuse the privilege.

MENTAL HEALTH INSURANCE DECREASES NON-PSYCHIATRIC CARE

A study[5] by the Group Health Association (GHA) in Washington, D.C., which covers Federal Employees, demonstrated that the provision of mental health services reduced substantially the amount of non-psychiatric care provided to a given population.

Two-hundred-fifty-six patients, who were members of GHA for twelve months prior to and after the study, were referred to out-patient psychiatric treatment. After referral, there was a significant reduction in their utilization of physicians services, laboratory and X-Ray procedures by that group. Reduction in overall utilization was 30%. Therefore, mental health insurance reduces substantially the amount of non-psychiatric medical care, and even more important, it results in provision of medical care *more appropriate* to the illness of the patients.

[4] Gorman, M. "Community Psychiatric Care: A New Era," National Conference of Mental Health, Jan. 26, 1968.

[5] Goldberg, I. Trantz, G. Locke, B. "Effect of Short Term Out-Patient Psychiatric Therapy Benefit on the Utilization of Medical Services in a Prepaid Group Practice Medical Program" *Medical Care* Sept.-Oct. 1970, Vol. 8, No.5.

Another study [6] compared the utilization of 152 patients who initially received mental health services from the Kaiser Foundation Health Plan, with a carefully matched control group of an equal number who were high medical care utilizers but who had not received psychiatric services. Among the control group there was no significant difference in medical care utilization for the first three years, but in the fourth and fifth year the control group increased their medical care utilization significantly; 27.2% in the fourth year and 13.28% in the fifth year. But for the group who had received psychiatric care, there was a decrease in non-psychiatric medical care utilization of 21.4% the first year, 39.2% the second year, 48.2% the third year, 52.3% the fourth year, and 62.5% the fifth year.

Insurance companies are now paying for medical services that evidently could have been treated at an earlier stage, without hospitalization and less cost if psychiatric care was provided. When no mental illness insurance is provided many patients waited until their mental problems affected them physically before treatment was sought out.

SUMMARY

There is no justification for excluding benefits for mental health services in all health insurance policies sold in this commonwealth.

1. Mental illness strikes indiscriminately among young and old, rich and poor. A need therefore exists for all people to be safeguarded against the high and sometimes crippling costs of professional mental health care today.

2. It has been demonstrated that mental health insurance is insurable at a reasonable cost for groups. Blue Cross indicates only a slight increase for non-group subscribers over what group members now pay for mental health benefits.

[6] Cummings, N. Follette, W.: "Psychiatric Services and Medical Utilization in a Prepaid Health Plan Setting" *Medical Care* Jan.-Feb. 1970, Vol. 5, No. 1.

3. There is a growing trend in this state towards community mental health care. No longer will institutionalization be the answer for the majority of the mentally ill.

Instead, out-patient treatment delivered close to home at early stages will be tomorrow's answer. In order to enlarge this system and make it available to millions of Massachusetts residents mental health insurance must be mandatory on our health insurance policies sold in this commonwealth.

4. Studies show that people who have mental health insurance do not abuse it, even with no limit to the number of services and with no co-payment. Mental health benefits are moderately utilized.

5. Mental health insurance significantly reduces the amount of non-psychiatric medical care to a given population. This indicates that people who do not have mental health insurance either wait until their illness physically affects them, or are being treated in a manner not appropriate to the illness.

6. There is a great potential for increased revenue to the commonwealth, because of 3rd party payments from insurance companies. Connecticut in their first year of their mental health insurance bill realized an increase in third party payments in the amount of 1.5 million dollars—an increase of approximately sixty percent. If Massachusetts had proportionately the same success with third party payments as Connectiut, a sixty percent increase could mean an additional six million dollars in revenue. Although this increase is a very optimistic one, the potential for increased revenue is there.

7. The most humanitarian reason for mandatory mental health insurance against the mentally ill is ended.

It means that the state, by making mental health insurance mandatory on all policies, officially recognizes that mental illness is a health problem that all must be protected against. No longer will the mentally ill be forced to go to a public institution instead of a local private institution because they could not get mental health insurance.

THE BLUE CROSS EXPERIENCE WITH MENTAL HEALTH INSURANCE

The Blue Cross system, which provides prepayment coverage for over 66 million members, provides some coverage for mental illness for at least 80 per cent of this number. The benefits vary by contract within Blue Cross area and range from a minimum coverage to one hundred per cent payments.

Prior to 1954 coverage for nervous and mental diagnoses was limited to ten days of inpatient care in an acute general hospital during the lifetime of a member. This limited coverage was not intended to be used for treatment of the patient. It was to provide benefits while a patient's illness was being diagnosed as a mental condition. Then, because in those days general hospitals did not, as a rule, treat mental illness, the patient was discharged, often to be admitted to a mental hospital.

In 1954 the new Prolonged Illness Certificate, a supplement to basic Blue Cross and Blue Shield, provided additional inpatient benefits up to $300 in an acute general hospital over and above the ten days in the basic certificate, and the 1954 Prolonged Illness Certificate included benefits for electric or insulin shock therapy for a bed patient, in the out-patient department, or in the doctor's office.

In 1956 Prolonged Illness Certificate holders' acute hospital benefits for mental illness were expanded to 120 days and an additional 60 days were provided in a mental

hospital. Out-of-hospital care was still limited to electric or insulin shock therapy.

Blue Cross's response to the demand for major medical coverage was introduced in 1956 through the known Master Medical contract. This contract provided for a dramatic liberalization of benefits for mental admissions in that it removed the restriction on the number of days. In other words, an unlimited number of days are provided although there is an overall maximum in terms of dollars. The overall maximum is usually $15,000. The Master Medical also provides for 60 days in a mental hospital with out-of-hospital benefits limited to electric or insulin shock therapy.

In February of 1968 a further expansion of benefits under the Master Medical contract was made by making available benefits for charges in connection with psychiatric services, other than electric shock treatments, in the out-patient department of Blue Cross participating hospitals up to a maximum amount of $300 in any calendar year. At the same time in-patient benefits for all basic group and non-group contracts were raised to 30 days a calendar year in an acute general hospital.

It is obvious that to date there has been an expansion of benefits under Blue Cross, but that the emphasis has been on in-patient care. Today Blue Cross is responsible for the administration of a number of programs involving more liberal coverage for mental illness.

The Program Available

1. Psychiatric coverage for United Auto Workers:—the program provides 45 days in-hospital care, including physician; other than in-patient care ($400 maximum)—(a) all hospitals-professional and other ancillary services available to ambulatory patients, (b) visits for therapy, (c) family counseling services, (d) group psychotherapy, and (e) psychological testing by psychologist when pre-

scribed by a psychiatrist. All of the above out-of-hospital care is available in the doctor's office, OPD facility, or day or night care facilities.

2. Psychiatric coverage for those in the Federal Employees program:—(a) 80% of the following physicians' services—initial evaluation, subsequent psychotherapy, and psychological testing; (b) 80% of prescription drugs; (c) 80% of included services in the OPD, clinic, and day/night care unit, including nurse and social worker services; (d) there is a deductible of $100 and 20% copay; the overall maximum is $50,000.

3. Psychiatric coverage under Medicare:—(a) hospital services—inpatient—90 days per spell of illness, lifetime maximum of 190 days, $40 patient deductible per admission, $10 patient copay 61st to 90th day; OPD diagnostic services—necessary diagnostic services, $50 annual patient deductible, 20% coinsurance on balance; and OPD therapeutic services; (b) physician's services as in-patient are all covered with a $50 patient deductible (OPD deductible is credited) and 20% coinsurance on balance; ambulatory services are (i) all physician services (ii) annual maximum payment based on the following basis—reasonable charges up to $500 annual maximum.

Although not provided through Blue Cross, except for the Division of the Blind, to complete the picture the following describes the psychiatric coverage under Medicaid:—(a) in-patient hospital services—unlimited days, no deductibles, copays, or coinsurance; no coverage in a state institution; (b) out-patient clinics—unlimited; (c) physicians' services—all necessary psychiatric services by a physician in the hospital (not a state institution), office, home, skilled nursing home, or elsewhere; (d) other services—prescribed drugs for use outside of the hospitals. Although there are no deductibles, copay, or coinsurance factors as such, there is a factor of monthly excess income, that amount that is in excess of the

monthly income requirements set by public welfare which has to be applied toward any and all monthly medical expenses. Blue Cross and Blue Shield, or any other insurance, would have to be applied initially. In other words, any amount payable under Medicaid must be reduced by the amount of the monthly excess income applicable to the expenses incurred in the same month.

In 1967, the Program Development staff at Blue Cross began developing a program to provide comprehensive ambulatory psychiatric benefits. They have consulted with the Massachusetts Mental Health Association, with representatives of the New England Branch of the American Psychiatric Association, with the Massachusetts Psychological Association, with officials of the State Department of Mental Hygiene, and of course with the management staff at Blue Cross and Blue Shield.

As a result, Blue Cross now offers an ambulatory psychiatric benefit plan to all Master Medical groups of 75 or more employees.

Specifically, the plan provides up to $700 in physician's services in a 24-month period. Because the plan pays physician's usual and customary charges, it provides full payment for physician's services, including:

1. the initial psychiatric evaluation
2. private and group psychotherapy
3. check-up visits
4. family interviews and counseling

In addition, the plan will provide up to another $700 in a 24-month period for other than physician's services—such as

1. psychological testing
2. services of a community mental health center, of a day or night care center, of a clinic, and services in a

hospital out-patient department. Payments to these institutions will include payment for the services of their psychiatric nurses and psychiatric social workers. Payments for these other than physician's services will be according to a liberal fee schedule.

The absence of a drug benefit under this program was intentional since drug coverage will be made available under the existing Master Medical contracts.

The monthly premium for this program is $.90 for an individual and $1.40 for a family.

In the development of this program Blue Cross has included benefits for all acceptable forms of evaluation and treatment; they have made benefits available in all acceptable and recognized facilities in which a physician has responsibility for a patient; they have removed the financial deterrent to seeking immediate care by offering first dollar coverage; they have provided for continuity of care from in-patient to out-patient, from out-patient to day care, from treatment in one setting to another, without penalties in the form of co-riders or deductibles, so that the patient's condition, and not the structure of his insurance benefits will dictate the course of the treatment.

The type of coverage provided by Blue Cross and the cost of the mental health rider effectively ruins the industry argument that this insurance is not financially feasible.

The committee felth that although Blue Cross had made good innovations over the years that mental health insurance must be made a mandatory feature on every plan. Thus, it was decided that one standardized plan for all health insurers would be drawn up.

ANALYSIS OF CHAPTER 1174

On January 1, 1972, Connecticut enacted Public Act 238 *, thus becoming the first state in the nation to insure its citizens against mental illness. The Connecticut act applies to group policies only, and provides for thirty days coverage for in-patient care.

In the 1973 legislative session, the Joint Committee on Insurance had before it a bill quite similar to the Connecticut act. The Committee favored the legislation and ordered a new study of the Connecticut act in order that loopholes might be closed.

The staff contacted many governmental and industry spokesmen in Connecticut, and found that Public Act 238 had been less than adequate. Generally it was suggested that any proposed legislation providing for mental illness insurance should contain the following provisions:

1. Coverage be provided under any medical benfits contract issued by any insurance company, hospital service corporation, medical service corporation, or employees health and welfare fund. They found difficulty in Public Act 238 which covers only insurance benefits sold on a group basis.
2. Mental or nervous conditions be any psychiatric disorders as included in the standard nomenclature of the American Psychiatric Association.
3. Benefits be included in any *existing* policy or contract as well as all *new* policies or contracts *issued* and *delivered* to a person *residing* or *employed* in your state.
4. That benefits be paid to any state facility, hospital, or institution which is accredited as a hospital or medical facility.

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* See Appendix A.

It can be seen that Chapter 1174 of the Acts of 1973 * reflects these changes and more. The Committee redrafted the legislation which contains the following main features:

1. Any group individual contract is to contain the mental illness provisions as well as Blue Cross-Blue Shield and Employees Health and Welfare Funds.
2. It applies to any policy which is issued or subsequently renewed.
3. It applies to all residents in the state, regardless of where the policy is purchased.
4. It is to cover any nervous or mental condition as described in the standard nomenclature of the American Psychiatric Association which are equal to the following minimum requirements:

(a) In the case of benefits based upon confinement as an in-patient in a mental hospital under the direction and supervision of the Department of Mental Health, or in a private mental hospital licensed by the Department of Mental Health, the period of confiement for which benefits shall be payable shall be at least sixty days of any calendar year.

(b) In the case of benefits based upon confinement as an in-patient in a licensed or accredited general hospital, such benefits shall be no different than for any other illness.

(c) In the case of out-patient benefits, these shall cover, to the extent of five hundred dollars over a twelve-month period, service furnished (1) by a comprehensive health service organization, (2) by a licensed or accredited hospital, (3) or subject to the approval of the Department of Mental Health clinic or day care center which furnishes mental health

services or (4) consultations or diagnostic or treatment sessions, provided that such services under this clause are rendered by a psychotherapist or a psychologist licensed under the provisions of Chapter 112.

5. The coverage is optional until January 1, 1974, wheneupon [*sic*] it will be mandatory on all health insurance policies.

The Committee believes that this legislation is the best in the country and hopes that other states will adopt this model.

IMPLICATIONS FOR STATE REVENUE GAIN

The pioneering experience of the state of Connecticut in enacting a law similar to Chapter 1174 is instructive from the point of view of revenue gain for the state.

It has been suggested that insurance coverage for psychiatric illness might lead potential patients away from state operated facilities to private facilities or psychiatrists. The implication is that the publicly-operated programs could not "stand the competition" and would lose "customers," with the result that there would be a loss of revenue to the state. The Connecticut experience indicates that this is not so. *In Connecticut since 1971 there has been an increase in revenue to the state from private health insurance payments to state hospitals and state operated clinics.* The figures on Connecticut substantiate this statement.

In FY 1971 the state of Connecticut received the following amount from private health insurance companies (Blue Cross and commercial carriers) for the in-patient care of mental illness: [7]

$2.5 million

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[7] Figures are reported by Charles Rourke, Supervisor, Institutional Accounts, Division of Central Collection, State of Connecticut, (Telephone interview, July 17, 1973).

In FY 1972 the state of Connecticut received from Blue Cross and other insurers the following amount:

$4 million

Thus, the state received additional revenue from private insurers after passage of the Connecticut act of approximately 1.5 million dollars. This figure for additional revenue is particularly interesting in the light of the fact that in 1972 Connecticut spent approximately the amount to operate its institutions as Massachusetts $84 million. In 1972 Massachusetts spent $82 million. It is not unrealistic to expect that our state can realize a comparable gain in revenue through passage of a psychiatric insurance bill such as Chapter 1174.

With regard to out-patient care, it is also clear that psychiatric insurance coverage does not result in declining revenue to state operated clinics. *Connecticut reports an increase in revenues to its state operated clinics and day care centers from private insurers between 1971 and 1972.* In 1971 Connecticut clinics and day care centers received approximately $547,000 in fees. In 1972 these clinics brought $645,000 in revenue to the state.

PAYMENTS TO STATE OPERATED OUT-PATIENT CLINICS

This year there will be approximately 360,000 patient visits to mental health clinics operated by the state of Massachusetts (located in community mental health centers or staffed by state hospital personnel).[8]

At the present time, these clinics are able to collect insurance payments from only about 2% of the patient who use them. The business managers of these clinics

[8] Based on figures for April, 1973. There were 29,910 visits to state operated mental health clinics in April, 1973. When multiplied by 12, the annual number of visits is 358,920. (Massachusetts Department of Mental Health, *Monthly Statistical Report,* April 1973).

estimate that 35% of the patients who use their clinics have some form of health insurance which covers hospitalization but not out-patient care. This situation would change, since Chapter 1174 requires *out-patient* as well as in-patient coverage. If the health insurance policies of those people who use these clinics were to include coverage for out-patient care (as required under Chapter 1174), these clinics would be able to collect close to a million dollars in third party payments ($921,014).[9]

The following example illustrates the potential for new revenue to the state through passage of Chapter 1174:

In FY 1972 the out-patient clinics at the Corrigan Mental Health Center in Fall River and the Solomon Mental Health Center in Lowell collected the following amounts through fees:[10]

Corrigan Mental Health Center (Fall River)	$ 4,024
Solomon Mental Health Center (Lowell)	11,954
Total	$15,978

As indicated, approximately 35% of the patients who use these clinics have some form of health insurance. If those people with health insurance who now use the clinics had policies which included out-patient care (as required under Chapter 1174) the two mental health centers would have been able to collect at least the following amounts from private insurers:[11]

Corrigan Mental Health Center (Fall River)	$ 34,327
Solomon Mental Health Center (Lowell)	89,362
Total	$123,689

This figure represents almost eight times more revenue for the state than the clinics have been able to collect in the past through fees from patients.

[9] Calculations are on the basis of current rates set by the Rate Setting Commission (see attached rate schedule).

[10] Figures from Massachusetts Department of Mental Health Financial Reports, 1972.

[11] Calculated on the basis of 11,566 out-patient visits to Corrigan and 16,058 to Solomon in 1972, using current per diem rates and assuming approximately 35% coverage through health insurance.

PART TWO

ALCOHOLISM INSURANCE

INTRODUCTION

The Joint Committee on Insurance saw the need to assure financing for hospital care and other health services for treatment of the disease* of alcoholism. The current ambivalent approach to the alcoholic has encouraged hospitalization under an inappropriate diagnosis; has failed to stimulate the development of proper medical and health care for the alcoholic; and has contributed to insurance costs due to late diagnosis.

PROBLEM STATEMENT

Since alcoholism is a complex disease with medical, psychiatric, psychological, social and vocational disorders, the treatment has to correspond to the complexity of the patient's condition. The total treatment must be multi-disciplinary in order to adequately deal with many disorders, either causative or sequential. It must offer acute care (detoxification), diagnostic evaluation, specialized treatment, ongoing aftercare, and where needed vocational rehabilitation and Alcoholics Anonymous.

Hospital insurance coverage for admission to a general or specialized hospital and participation in hospital aftercare programs are among those services often "unavailable" to alcoholics. Continuity of care, between inpatient and out-patient services so necessary to the successful rehabilitation of the alcoholic, is not covered by insurance and therefore is too often lacking.

It is apparent that the alcoholic needs a specific and comprehensive treatment program to enable him to regain total health. All phases of this treatment for the

* See Appendix C.

disease of alcoholism should be included in insurance coverage. It should be emphasized that the treatment program carried out in the general hospital setting is usually for late complications and is not directed to a comprehensive program for the alcoholic.

EXISTING GAPS

In its discussion the committee recognized that the development of adequate financing of care for the disease alcoholism required the development of broad and intensive educational programs. Current lack of understanding of this disease and requirements for its treatment, on the part of employers, insurance companies, and many others is of serious concern, for it does inhibit prompt development or broad insurance coverage and permits continued wasteful and ineffective expenditures on the part of the insurance companies and others.

Proposed grant-in-aid legislation, or private, or local community funds may provide for the initiation of specialized programs for alcoholics. To insure the continuation and stable operation of these programs, while providing for their growth, requires the development of stable financing mechanisms. Provisions for such stability in financing the treatment for alcoholism can be provided by extending the same basic coverage that is given to treatment of other diseases. The bulk of the alcoholic patient population is adequately insured and treated for other illnesses caused by alcoholism; therefore, it seems logical that the same insurance should cover treatment for this disease.

The committee is aware of the urgent need for additional treatment facilities and manpower. It is obvious that the further development of facilities and the support of trained manpower can be expected to follow the development of adequate insurance mechanisms.

Theoretically an insurance company will write any kind of coverage requested by the purchaser including

coverage for treatment of alcoholism. In reality many policies are written either with the exclusion of alcoholism or with reduced benefits. The reasons for this are included among the following issues: (1) lack of willingness on the part of the purchaser to pay the additional costs required for the extended benefits; or (2) because of a reluctance on the part of the insurance company to recommend coverage fearing that the excessive costs may cause the contract to be less competitive. When coverage is provided it is often limited by the following: (1) coverage only in a *general hospital* with a limited number of days allowed which may vary from 15 to 30 days and may limit this to only once a year; (2) coverage limited under the *sanitoria* clause providing for a predetermined per diem rate and a designated number of days; or (3) coverage limited under the *mental and nervous disorder* clause limiting not only the number of days for hospitalization but also the percent of cost coverage.

STANDARDS FOR TREATMENT

The committee feels that alcoholism should not be considered exclusively as a mental disorder ignoring the physiological ramifications but that especially with alcoholism the maintenance of total health is the prime concern. Insurance benefits should provide complete coverage on an in-patient and out-patient basis whether in a general or special hospital. Specialized treatment facilities properly licensed and accredited where a patient is diagnosed and treated by a multi-disciplinary team functioning under the jurisdiction of a physician, should be acceptable for full insurance coverage.

Guidelines for a total treatment program should include medical evaluation, treatment, and supervision for the acute toxic metabolic phase of the illness, commonly referred to as detoxification and which is preliminary to comprehensive diagnostic and treatment program for the alcoholic and his family.

Such a program may be conducted in a general or special hospital in its entirety or in the form of a program which they conduct cooperatively. It will require (a) hospital licensure; (b) a staffing pattern adequate to meet the objectives of a comprehensive alcoholism treatment program; and (c) an organized medical staff with provision for 24 hour nursing care.

A comprehensive diagnostic treatment program should include evaluation, didactic lectures, as well as a group and individual psychotherapy program under ongoing medical supervision. To provide such a program a multidisciplinary staff is required including the utilization of recovered alcoholic counselors.

RECOMMENDATIONS OF THE COMMITTEE

1. That alcoholism be covered to the extent of the basic policy in every health insurance plan operable in Massachusetts.
2. That insurance coverage should be flexible to permit individualized treatment of the alcoholic as determined by the hospital staff, and to include both in-patient and out-patient care.
3. That insurance carriers be urged and encouraged to conduct educational programs for their staffs so as to develop better understanding of alcoholism.
4. That companies—management and unions—recognize their role and responsibilities for creating a better understanding of alcoholism.
5. That management and labor accept their responsibilities to work together with their health insurance carrier to provide comprehensive health services for the alcoholic employee.
6. That health and compensation insurance carriers inaugurate insurance alcoholism programs simi-

lar to safety engineering programs designed for early referral and treatment of alcoholism in business and industry with the consequent reduction of economic losses due to alcoholism.

7. That the committee urges that efforts be made to have health insurance carriers and providers of health services work together to develop sound statistical and fiscal data with respect to the disease of alcoholism to facilitate sound program and fiscal planning for the future.

ANALYSIS OF CHAPTER 1221

In 1971 the state of Wisconsin passed Assembly Bill 1348 * which provided for the coverage of alcoholism in all health insurance policies, effective in September 1972.

When the Joint Committee on Insurance decided to pursue this type of legislation in 1973 the Wisconsin legislation was discarded as being too vague and full of loopholes. Therefore, the committee staff decided to use the wording developed in the Mental Health Act, Chapter 1174. For all intensive purposes, the analysis of the two acts is the same, except for the benefits which are to be equal to at least the following: **

(a) In the case of benefits based upon confinement as an in-patient in an accredited or licensed hospital or in any other public or private facility thereof providing services especially for the detoxification or rehabilitation of intoxicated persons or alcoholics and which is licensed by the Department of Public Health for those services, such benefits shall be at least thirty days in any calendar year.

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* See Appendix D.

** See Appendix E.

(b) In the case of out-patient benefits these shall cover, to the extent of five-hundred dollars over a twelve-month period, services furnished by (1) an accredited or licensed hospital, or by (2) any public or private facility or portion thereof providing services especially for the rehabilitation of intoxicated persons or alcoholic and which is licensed by the Department of Public Health for those purposes.

(c) The provisions of the legislation are optional to the policyholder until January 1, 1976, when they shall become mandatory.

PART THREE

NEWBORN HEALTH INSURANCE

INTRODUCTION

The Newborn Health Insurance Act of 1974, Chapter 785, provides for immediate insurance coverage to new born children on all family insurance programs offered in the Commonwealth. At the present time many major medical insurance policies do not provide coverage for immediate care of new born children. There are often exclusions from 10 to 35 days after birth and many policies exclude congenital defects from coverage forever.

This legislation is a necessity because the cost of medical care for new born children with congenital medical problems has often resulted in bankruptcy for young families. Many young parents are often unaware that their medical policy holds an exclusion in coverage for the early days of a child's life. On the other hand, incidence of these cases is actually low enough in comparison with the general cost of health insurance that it would not greatly affect cost of commercial insurance policies. The average cost of the expanded coverage has been only $5.00 per year in the seven states which have already adopted the legislation.

In Massachusetts, out of 80,000 births, 700 new born infants were transferred to special care nurseries for urgent medical care. During the period 1972-1973 at the Boston Hospital for Women, one to three percent of newborns required care for major congenital abnormalities. Many of these infants were without insurance coverage under present policies.

Blue Cross, which provides for about 60 percent of the health care insurance for the state has now adopted this provision. In general, the need remains among the other 40 percent of insurance providers.

When this provision was added to existing coverage in California by Blue Cross in October 1973, the cost to date has turned out so small that no additional premium at all was required for the program.

Mandatory legislation would clearly not place difficult financial burden upon insurance carriers in terms of marketing such a policy nor upon the consumer in purchasing such a policy.

ANALYSIS OF CHAPTER 785

The language of Chapter 785* providing for newborn health insurance is drawn from the two proceeding health insurance acts. The Committee decided that for the purposes of uniformity in the General Laws and to protect against loopholes in the "Model Newborn Insurance Program", an industry favored bill, the language evolved in the last session would be superior.

The Committee also favored a feature in the bill that would protect the insurance consumer in the event of a failure to notify the insurance carrier of a new dependent. The bill states that in the event a policyholder fails to notify the company, a submission of a claim will serve as notification.

Newborn children in Massachusetts from January 1, 1975 onward will now be covered at the moment of birth for ordinary accident and sickness benefits as well as congenital birth abnormalities and premature birth.

No longer will the threat of financial disaster result from complications at birth.

PART FOUR

APPENDIX

APPENDIX A

Substitute House Bill No. 5076

Public Act No. 238

AN ACT CONCERNING PROVISION IN HEALTH INSURANCE POLICIES, HOSPITAL SERVICE CONTRACTS AND MEDICAL SERVICE CONTRACTS FOR BENEFITS AGAINST MENTAL ILLNESS COSTS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Notwithstanding any provision to the contrary in the general statutes, no medical benefits contract on a group basis, whether issued by an insurance company, a hospital service corporation or a medical service corporation shall be sold in this state unless persons covered under such contract will be eligible for benefits for expense arising from mental or nervous conditions which are at least equal to the following minimum requirements: (a) In the case of benefits based upon confinement as an in-patient in a hospital, the period of confinement for which benefits shall be payable shall be at least thirty days in any calendar year. (b) In the case of major medical expense coverage, benefits, after the applicable deductible, shall be at a fifty per cent rate for covered expenses incurred by the insured while other than an in-patient in a hospital, and benefits shall be available for such expenses during any calendar year up to a maximum of five hundred dollars.

Section 2. This act shall take effect January 1, 1972.

Certified as correct by

_____

Legislative Commissioner

_____

Clerk of the Senate

_____

Clerk of the House

Approved _____, 1971

_____

Governor

APPENDIX C

I. *STATEMENTS ON ALCOHOLISM:*

House of Delegates, American Medical Association, 1956: "Alcoholic symptomatology and complications which occur in many personality disorders came within the scope of medical practice. Acute alcoholic intoxication can be and often is a medical emergency."

American Hospital Association, 1967: "Alcoholism is a serious health problem. It falls within the scope of medical practice and it is often a medical emergency. The alcoholic should not be denied the advantage of a thorough study of the cause or causes of his condition and should not be denied the advantage of the best possible management of his case."

American Psychiatric Association, 1965: "All prepayment plans for defraying the cost of medical care through insurance should cover the person presenting symptoms of alcohol problems who seeks treatment in medical settings on the same basis as for other illnesses."

II. *DEFINITION:*

ALCOHOLISM IS AN ILLNESS CHARACTERIZED BY PREOCCUPATION WITH ALCOHOL AND LOSS OF CONTROL OVER ITS CONSUMPTION SUCH AS TO LEAD USUALLY TO INTOXICATION IF DRINKING IS BEGUN; BY CHRONICITY; BY PROGRESSION; AND BY TENDENCY TOWARD RELAPSE. IT IS TYPICALLY ASSOCIATED WITH PHYSICAL DISABILITY AND IMPAIRED EMOTIONAL, OCCUPATIONAL, AND/OR SOCIAL ADJUSTMENTS AS A DIRECT CONSEQUENCE OF PERSISTENT AND EXCESSIVE USE.

COMMONWEALTH OF MASSACHUSETTS
TRIAL COURT
SUPERIOR COURT DEPARTMENT

SUFFOLK, SS.

Civil Action No. 35598

COMMONWEALTH OF MASSACHUSETTS, PLAINTIFF

—*against*—

THE TRAVELERS INSURANCE COMPANY

—and—

METROPOLITAN LIFE INSURANCE COMPANY, DEFENDANTS

[Filed Sept. 24, 1980]

STIPULATION

1. Metropolitan Life Insurance Company ("Metropolitan") has approximately 80 group insurance contracts in force which were issued outside of the Commonwealth of Massachusetts prior to January 1, 1976 and which provide medical expense coverage to approximately 40,400 Massachusetts employees. To the extent such data is available, Exhibit A hereto provides, for certain of those contracts, the approximate number of employees residing within and outside of the Commonwealth of Massachusetts.

2. Metropolitan has approximately 28 group insurance contracts in force which were issued outside of the Commonwealth of Massachusetts on or after January 1, 1976 and which provide medical expense coverage to approximately 3,528 Massachusetts employees. To the extent such data is available, Exhibit B hereto provides, for

certain of those contracts, the approximate number of employees residing within and outside of the Commonwealth of Massachusetts.

3. Metropolitan has approximately 33 group insurance contracts in force which were issued within the Commonwealth of Massachusetts prior to January 1, 1976 and which provide medical expense coverage to approximately 8,600 Massachusetts employees. To the extent such data is available, Exhibit C hereto provides, for certain of those contracts, the approximate number of employees residing within and outside of the Commonwealth of Massachusetts.

4. Metropolitan has approximately 28 group insurance contracts in force which were issued within the Commonwealth of Massachusetts on or after January 1, 1976 and which provide medical expense coverage to approximately 20,100 Massachusetts employees. To the extent such data is available, Exhibit D hereto provides, for certain of those contracts, the approximate number of employees residing within and outside of the Commonwealth of Massachusetts.

5. The Travelers Insurance Company ("Travelers") has approximately 57 group insurance contracts in force which were issued outside of the Commonwealth of Massachusetts prior to January 1, 1976 and which provide medical expense coverage to approximately 14,000 Massachusetts employees. To the extent such data is available, Exhibit E hereto provides, for certain of those contracts, the approximate number of employees residing within and outside of the Commonwealth of Massachusetts.

6. Travelers has approximately 27 group insurance contracts in force which were issued outside of the Commonwealth of Massachusetts on or after January 1, 1976 and which provide medical expense coverage to approximately 13,000 Massachusetts employees. To the extent

such data is available, Exhibit F hereto provides, for certain of those contracts, the approximate number of employees residing within and outside of the Commonwealth of Massachusetts.

7. Travelers has approximately 2,150 group insurance contracts in force which were issued within the Commonwealth of Massachusetts and which provide medical expense coverage to approximately 45,000 Massachusetts employees. Of these contracts, an estimated 60% to 70% were issued prior to January 1, 1976.

8. Virtually all of Metropolitan's and Travelers' group insurance contracts in force providing medical expense coverage to Massachusetts employees were issued to provide benefits for employee benefit plans subject to the Employee Retirement Income Security Act of 1974 ("ERISA"). There are, however, a few such contracts issued to provide benefits for plans not subject to ERISA, such as church or government plans as defined in ERISA. With respect to all or virtually all Metropolitan policies, Metropolitan acts as the named fiduciary for the review of denied claims pursuant to ERISA. Exhibit G hereto is a copy of the standard ERISA conforming instrument entered into by Metropolitan and its policyholders.

9. Metropolitan has approximately 49 group insurance contracts in force which were issued within the Commonwealth of Massachusetts on or after January 1, 1976, or which were issued within the Commonwealth of Massachusetts before January 1, 1976 and for which Metropolitan reserved the unilateral right to non-renew the contract, and which provide the benefits specified in G.L. c. 175, § 47B. Travelers has approximately 2,150 group insurance contracts in force which were issued within the Commonwealth and which provide the benefits specified in G.L. c. 175, § 47B. As a matter of policy and voluntary decision, defendants and those policyholders have provided the benefits specified by G.L. c.

175, § 47B. This paragraph is without prejudice to defendants' rights to assert any claims of fact or law in this action.

10. Certain of Metropolitan's and Travelers' group insurance contracts in force providing medical expense coverage to Massachusetts employees were issued to provide benefits for employee benefit plans which are the product of collective bargaining agreements negotiated subject to the National Labor Relations Act. Certain of these collective bargaining agreements prescribe the particular type and level of medical expense benefits to be afforded employees while others prescribe the level or amount of contributions to be afforded employees, and the particular group insurance contract implements the terms of the collective bargaining agreement.

11. The preponderance of insurance policies affected by G.L. c. 175, § 47B have been issued to employers. A substantial number of these employers engage in business operations in other states as well as in Massachusetts, and have employees who live and work in such other states as well as in Massachusetts.

12. The Commonwealth is not seeking to enforce that part of G.L. c. 175, § 47B purporting to affect employee health and welfare plans directly.

13. The subject of health benefits, including mental health benefits, is a mandatory subject to collective bargaining, as to which employers subject to the National Labor Relations Act have a duty to bargain.

14. More than 20% of the gross revenue from Metropolitan's trade or commerce is derived from transactions in interstate commerce. This is also true with respect to Travelers.

More than 20% of the gross revenue from Metropolitan's trade or commerce is derived from transactions in interstate commerce, excluding all transactions and ac-

tions which occur primarily and substantially within the Commonwealth. This is also true with respect to Travelers.

15. The Report of Joint Committee on Insurance dated August 1974, copies of which are in the possession of the parties, is authentic and may be accepted in evidence.

16. (a) The following is Metropolitan's standard group insurance contract "Renewal Privilege" provision generally in use for contracts issued from 1940 through 1975:

> RENEWAL PRIVILEGE—This Policy is issued for a period commencing with the date of issue and ending with the day immediately preceding on which last date and on each anniversary of which last date the Employer may renew this Policy for a further term of one year, provided (1) the number of Employees then insured hereunder for Personal Insurance is, in the case of Contributory Insurance, not less than seventy-five percent of the number of eligible Employees and, in the case of Non-Contributory Insurance, not less than the total number of eligible Employees, and provided, in either case, the number of Employees then insured hereunder for Personal Insurance is not less than fifty and (2) the number of Employees insured hereunder for Dependent Insurance is, in the case of Contributory Insurance, not less than seventy-five percent of the number of eligible Employees with Dependents and, in the case of Non-Contributory Insurance, not less than the total number of eligible Employees with Dependents. Such renewal is conditioned upon the payment of the premium then due as computed in the manner set forth in Section 16 hereof and based upon such premium rates as may then be determined by the Insurance Company. (Exhibit H hereto is a copy of Section 16 referred to above.)

(b) The following is Metropolitan's standard group insurance contract "Renewal Privilege" provision generally in use for contracts issued from 1976 through 1978. Certain contracts issued in 1975 also contained this provision.

> RENEWAL PRIVILEGE—This Policy may be renewed on any renewal date for a further period ending with the day immediately preceding the next renewal date, subject to the following provisions. Renewal is conditioned upon the payment of the premiums then due as computed in the manner set forth in Section 6 and based upon such premium rates as may then be determined by the Insurance Company. (Exhibit I hereto is a copy of Section 6 referred to above.)
>
> The Insurance Company reserves the right to decline to renew this Policy on any renewal date (a) if the number of Employees then insured for each type of insurance provided hereunder is less than 75%* of the number of Employees eligible for such insurance, or (b) if the number of Employees then insured hereunder is less than 50.*

* Although the standard is 50, the number may be greater in certain contracts.

(c) Metropolitan group insurance contracts issued in 1979 and thereafter generally do not include a provision labelled "Renewal Privilege". The following is Metropolitan's standard group contract "Discontinuance Of The Policy" provision generally included in group contracts issued in 1979 and thereafter:

> DISCONTINUANCE OF THE POLICY—Metropolitan will have the right to discontinue this Policy if less than 75%* of the eligible Employees are insured for each type of insurance. Metropolitan will also have such right if less than 50* Employees are insured. Such right may be exercised by Metropolitan only on the last day of the first Policy Period or on the day before any Premium Due Date which occurs after the last day of the first Policy Period. Notice, in writing, that this Policy is to be discontinued must be given to the Employer by Metropolitan. The notice must be given at least thirty-one days** prior to the date this Policy is to be discontinued.

* Change to 100% in the case of non-contributory insurance. Not less than 75% in the case of contributory insurance.

(d) Certain large groups have non-standard provisions in their group insurance contracts.

(1) The following "Renewal Privilege" provision forms the basis for the type of provision generally used for these groups:

> RENEWAL PRIVILEGE—This Policy may be renewed on any renewal date for a further period ending with the day immediately preceding the next renewal date, subject to the following provisions. Renewal is conditioned upon the payment of the premiums then due as computed in the manner set forth in Section 6 and based upon such premium rates as may then be determined by the Insurance Company.
>
> The Insurance Company reserves the right to decline to renew this Policy on any renewal date (a) if the number of Employees then insured for each type of insurance provided hereunder is less than 75% of the number of Employees eligible for such insurance, or (b) by giving at least ninety days prior written notice to the Employer.

* Although the standard is 50, the number may be greater in certain contracts.

** Although the standard is 31, the number may be changed to a longer period of up to 90 days in certain contracts.

(2) The following "Renewal Privilege" provision is an example of a provision presently contained in one such large group contract.

> RENEWAL PRIVILEGE—This Policy is issued for a period commencing with the date of issue and ending with the day immediately preceding January 1, 1956, on which last date and on each anniversary of which last date the Employer may renew this Policy for a term of one year, except that the Insurance Company reserves the right to discontinue this Policy on December 31, 1960 or on the day preceding any subsequent renewal date by giving written notice to the Employer at least

17. With respect to virtually every one of the Metropolitan insurance contracts referred to in paragraphs 1 through 4 above, since January 1, 1976 the specific benefits provided pursuant to each particular contract and the premium paid under that contract have changed. With respect to virtually all of those insurance contracts, premiums have increased to account for inflation as well as expansions of the benefit package. It is common for the premiums of many of those contracts to be increased annually.

18. Exhibit J hereto is a standard form of group insurance policy presently used by Travelers. The marked portions (which relate to continuity and discontinuance of the policy and modifications of the policy, including premium rate changes) have been virtually unchanged for the past 30 years.

19. With respect to virtually every one of the Travelers insurance contracts referred to in paragraphs 5 and 6 above, since January 1, 1976 the specific benefits provided pursuant to each particular contract and the premium paid under that contract have changed. This is also true with respect to a substantial number of the Travelers insurance contracts referred to in paragraph

7 above. With respect to virtually all of those insurance contracts, premiums have increased to account for inflation as well as expansions of the benefit package. It is common for the premiums of many of those contracts to be increased annually.

20. Exhibits K and L hereto are copies of current model or sample provisions for major medical expense benefits, including mental health benefits, which are offered by Metropolitan and Travelers, respectively, to their policyholders. These provisions are used in the absence of policyholder requests for different provisions. A substantial number of times they are accepted by policyholders.

21. Certain of Metropolitan's and Travelers' insurance contracts have undergone changes in the areas of mental health, retirees or surgical benefits or in other related areas of benefits or eligibility. Examples of such changes in the areas of mental health, retirees and surgical benefits are attached hereto as Exhibits M (Metropolitan) and N (Travelers).

22. With respect to G.L. c. 175, § 47B ("Section 47B"), there is: (a) substantial compliance by Metropolitan and substantial noncompliance by Travelers with Section 47B(a); (b) substantial compliance by Metropolitan and Travelers with Section 47B(b); and (c) substantial noncompliance by Metropolitan and Travelers with Section 47B(c).

23. Defendants' exhibit reflecting the number of "Administrative Services Only" contracts issued by Metropolitan in recent years is authentic and may be admitted into evidence.

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COMMONWEALTH OF MASSACHUSETTS
SUPERIOR COURT
DEPARTMENT OF THE TRIAL COURT

SUFFOLK, SS.

Civil Action No. 35598

COMMONWEALTH OF MASSACHUSETTS, PLAINTIFF

v.

THE TRAVELERS INSURANCE COMPANY
METROPOLITAN LIFE INSURANCE COMPANY, DEFENDANTS

[Filed Sept. 25, 1980]

STIPULATION

1. During the years 1976-1980, the Commonwealth of Massachusetts expended the following amounts for institutional mental health care, including care for alcoholism and drug abuse, and for all other mental and nervous disorders.

1976	1977	1978	1979	1980	
87.6	86.8	93.1	96.4	88.4	Million

2. During the years 1976-1980, the Commonwealth of Massachusetts expended the following amounts for community based mental health care, including care for alcoholism and drug abuse, and for all other mental and nervous disorders.

1976	1977	1978	1979	1980	
26.8	36.8	45.1	60.5	108.3	Million

These funds are distributed to public and private community mental health centers, and other community men-

tal health organizations, a substantial number of which derive a substantial portion of their revenue from third party insurance payments.

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Sept. 25, 1980

COMMONWEALTH OF MASSACHUSETTS
TRIAL COURT
SUPERIOR COURT DEPARTMENT

SUFFOLK, SS.

Civil Action No. 35598

COMMONWEALTH OF MASSACHUSETTS, PLAINTIFF

against

THE TRAVELERS INSURANCE COMPANY

and

METROPOLITAN LIFE INSURANCE COMPANY, DEFENDANTS

[Filed Sept. 25, 1980]

SUPPLEMENTAL STIPULATION

1. Virtually all claims submitted by or on behalf of Massachusetts residents pursuant to Metropolitan's group insurance contracts in force are received, reviewed, processed, and paid or denied outside of the Commonwealth of Massachusetts. In certain cases, Metropolitan policyholders with operations within the Commonwealth will be responsible for the actual transmission of claims from employees to Metropolitan.

2. With respect to certain of Travelers' group insurance contracts in force which were issued outside of the Commonwealth of Massachusetts, claims submitted by or on behalf of Massachusetts residents pursuant to such contracts are received, reviewed, processed and paid or denied outside of the Commonwealth. With respect to certain other of Travelers' contracts in force which were

issued outside of the Commonwealth, including the contract issued to G.T.E., some claims are received, reviewed, processed and paid or denied within the Commonwealth and some claims are received, reviewed, processed and paid or denied outside the Commonwealth.

3. The policy clauses referred to in paragraph 16(a) and (b) of the initial Stipulation and the marked clauses referred to in paragraph 18 of that Stipulation are contained in many of defendants' group insurance contracts in force covering Massachusetts residents and issued prior to January 1, 1976. Under these clauses, a policyholder may exercise its right to non-renew or discontinue its contract even if claims paid and expenses incurred by the insurer exceeded premium payments made to the insurer. This may leave the insurer with a net loss under the contract which it would be unable to recover from the policyholder. Even if the policyholder does not non-renew or discontinue the contract under those circumstances, the insurer will often be unable to recover the loss during the subsequent year.

4. There are approximately 82 community mental health centers and clients subject to reimbursement pursuant to G.L. c. 175, § 47B(c)(3).

5. The inpatient population of Massachusetts state mental hospitals has decreased from approximately 13,482 in 1969 to approximately 2,328 in 1980.

No. 84-325

METROPOLITAN LIFE INSURANCE COMPANY, APPELLANT

v.

COMMONWEALTH OF MASSACHUSETTS

Appeal from the Supreme Judicial Court
of Massachusetts

The statement of jurisdiction in this case having been submitted and considered by the Court, in this case probable jurisdiction is noted. This case is consolidated with case No. 84-356, *Travelers Insurance Company* v. *Commonwealth of Massachusetts*, and a total of one hour is allotted for oral argument.

October 29, 1984

No. 84-356

TRAVELERS INSURANCE COMPANY, APPELLANT

v.

COMMONWEALTH OF MASSACHUSETTS

Appeal from the Supreme Judicial Court
of Massachusetts

The statement of jurisdiction in this case having been submitted and considered by the Court, in this case probable jurisdiction is noted. This case is consolidated with case No. 84-325, *Metropolitan Life Insurance Company* v. *Commonwealth of Massachusetts*, and a total of one hour is allotted for oral argument.

October 29, 1984

(12)

Office - Supreme Court, U.S.
FILED
DEC 21 1984
ALEXANDER L. STEVAS
CLERK

No. 84-325

In the Supreme Court of the United States

OCTOBER TERM, 1984

METROPOLITAN LIFE INSURANCE COMPANY, APPELLANT

v.

COMMONWEALTH OF MASSACHUSETTS

On Appeal from the Supreme Judicial Court for the Commonwealth of Massachusetts

---

BRIEF FOR APPELLANT

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QUESTION PRESENTED

Whether a state statute that requires insured employee benefit plans to provide specified minimum benefits for certain kinds of medical services is preempted by Section 514(a) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1144(a).*

---

* Metropolitan Life Insurance Company and The Travelers Insurance Company were the appellants in the Supreme Judicial Court of Massachusetts. Travelers has also docketed an appeal to this Court (No. 84-356), and the Court has noted probable jurisdiction in that case as well. Travelers' brief on appeal will discuss a question regarding preemption under the National Labor Relations Act, 29 U.S.C. 151 *et seq.* Metropolitan joins in Travelers' arguments concerning the NLRA and incorporates them by reference in this brief.

In accordance with Rule 28.1 of the Rules of this Court, Metropolitan states that, other than wholly-owned subsidiaries, it has only one subsidiary in which it owns a controlling interest of more than 50%. That subsidiary is Dawn Water Company.

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In the Supreme Court of the United States

OCTOBER TERM, 1984

No. 84-325

METROPOLITAN LIFE INSURANCE COMPANY, APPELLANT

v.

COMMONWEALTH OF MASSACHUSETTS

On Appeal from the Supreme Judicial Court for the Commonwealth of Massachusetts

---

BRIEF FOR APPELLANT

OPINIONS BELOW

The April 1984 opinion of the Supreme Judicial Court of Massachusetts (J.S. App. 1a-8a)[1] is reported at 391 Mass. 730 and 463 N.E.2d 548. The earlier opinion of that court (J.S. App. 13a-34a) is reported at 385 Mass. 598 and 433 N.E.2d 1223. The findings and conclusions of the state trial court (J.S. App. 36a-62a) are not reported. The trial court's opinion on appellee's motion for preliminary injunctive relief (J.S. App. 71a-84a) is not reported.

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[1] "J.S. App." refers to the separately bound appendix to the jurisdictional statements in this case and No. 84-356.

JURISDICTION

The judgment of the Supreme Judicial Court of Massachusetts (J.S. App. 9a) was entered on April 25, 1984. A notice of appeal to this Court (J.S. App. 93a-94a) was filed on May 29, 1984. On July 12, 1984, Justice Brennan extended the time for docketing the appeal to September 22, 1984 (84-325 J.S. Appendix).[2] The appeal was docketed on August 30, 1984. On October 29, 1984, this Court noted probable jurisdiction (A. 474).[3] The jurisdiction of this Court rests on 28 U.S.C. 1257(2).

STATUTORY PROVISIONS INVOLVED

Section 47B of Massachusetts General Laws Chapter 175 and the relevant provisions of the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001 *et seq.*, are reprinted in J.S. App. 85a-89a.

STATEMENT

A. Factual Background

In 1974, after extended study, Congress enacted the Employee Retirement Income Security Act ("ERISA") to protect the interests of participants in employee benefit plans and to enable such plans to be administered on a uniform, nationwide basis. To achieve these goals, Congress sought to occupy the regulatory field fully and thereby to eliminate the problems caused by diverse, patchwork state legislation. In Section 514(a) of ERISA, 29 U.S.C. 1144(a), Congress explicitly preempted all state laws that regulate, directly or indirectly, employee benefit plans covered by the federal statute. In unmistakable terms, Section 514(a) provides that the federal law "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan * * *."

[2] The citation refers to the appendix bound together with the jurisdictional statement in this case, No. 84-325.

[3] "A." refers to the joint appendix filed in this Court by the parties in Nos. 84-325 and 84-356.

In 1973, shortly before the enactment of ERISA, but well after congressional consideration of the proposed legislation (including the clauses at issue here) had begun, the Massachusetts legislature passed the "mandated benefit" statute at issue in this case. The state law, Section 47B of Massachusetts General Laws Chapter 175, requires that employee health and welfare plans covering Massachusetts residents provide certain specified minimum benefits for the care of mental and nervous conditions. The law also requires that health insurance policies sold to such plans provide coverage for the same minimum benefits.[4] Section 47B became effective on a mandatory basis on January 1, 1976.[5]

[4] In particular, Section 47B requires that employee benefit plans and health insurance policies satisfy the following minimum requirements (J.S. App. 88a-89a):

> "(a) In the case of benefits based upon confinement as an inpatient in a mental hospital under the direction and supervision of the department of mental health, or in a private mental hospital licensed by the department of mental health, the period of confinement for which benefits shall be payable shall be at least sixty days in any calendar year.
>
> "(b) In the case of benefits based upon confinement as an inpatient in a licensed or accredited general hospital, such benefits shall be no different than for any other illness.
>
> "(c) In the case of outpatient benefits, these shall cover, to the extent of five hundred dollars over a twelve-month period, services furnished [by persons or institutions having certain specified qualifications]."

[5] As indicated in the jurisdictional statement of appellant Metropolitan (84-325 J.S. 8-9 n.5), approximately half the states have now enacted mandated benefit statutes, state laws that require health insurance policies to provide coverage for a particular illness or condition. Under such statutes, any ERISA plan that purchases insurance is required to provide the mandated benefit.

In addition, a variety of other state laws attempt to affect the health benefits provided by insured ERISA plans. Some such laws

Appellants provide health insurance for employee benefit plans.[6] Following the enactment of ERISA and its broad preemption clause, appellants concluded that Section 47B could not properly be applied to employee benefit plans or to the health insurance policies they purchase. For this reason (among others), when an ERISA plan did not wish to include in its benefit package the benefits specified in Section 47B, appellants acquiesced and issued to that plan a policy that contained only the coverage desired. As a consequence, participants in such plans were not required to pay for the benefits mandated by Section 47B.

Massachusetts has not sought to enforce Section 47B to the extent it applies directly to ERISA plans. Appellee concedes that ERISA precludes direct state prescription of the benefits that must be provided by such plans (J.S. App. 43a, 59a). But, appellee maintains, and the court below held, states may nevertheless determine the benefits that insured ERISA plans must provide. They may do so, appellee contends, simply by dictating the content of health insurance policies available to ERISA plans. Thus, according to appellee and the court below, a state *may not* mandate the benefits to be provided by an uninsured ERISA plan but *may* mandate the benefits to be provided by an insured ERISA plan.

provide that if certain kinds of treatment are covered by health insurance, they must be covered regardless of the provider of the health services used. Others require that certain coverage be offered but not that it be purchased. A survey of the numerous state laws governing the content of health insurance policies is provided as an appendix to the brief submitted by the Health Insurance Association of America at the jurisdictional statement stage. Only mandated benefit statutes are at issue on this appeal.

[6] Among the ERISA plans covered by Metropolitan policies is General Electric Company's employee health insurance plan, which provides coverage to approximately one million persons nationwide. For many years, General Electric has observed a uniform benefits policy for all plan members. A. 99-100 (testimony of John Morris, a senior General Electric employee responsible for the company's insured health benefit plan).

Nowhere is it contended that the distinction between insured and uninsured plans comports with any statutory purpose or makes any sense. On the contrary, both appellee and the court below acknowledge that the distinction undermines important policies that ERISA sought to achieve—the promotion of uniform and solvent health plans. Nevertheless, the distinction is made because of the so-called "insurance savings clause" in ERISA, Section 514(b)(2)(A). That clause provides that nothing in the statute "shall be construed to exempt or relieve any person from any law of any State which regulates insurance * * *." 29 U.S.C. 1144(b)(2)(A).

While Massachusetts and the court below would reach the same result, each has adopted a different rationale, and each has rejected the reasoning of the other. Appellee's position has been that since Section 47B deals with insurance, it is automatically within the language of the savings clause and not preempted. The court below expressly rejected such an interpretation because it would "reach far into areas governed by ERISA, and thereby negate the unmistakable intent of Congress to work a broad preemption" (J.S. App. 21a). The court below held that the statute is not preempted because its subject matter, health benefits, is not expressly regulated by ERISA. The Commonwealth has not advanced this "conflict-based" argument, apparently because it is expressly refuted by this Court's holding in *Shaw* v. *Delta Air Lines*, 103 S. Ct. 2890 (1983).

Both appellee and the court below were unwilling to accept appellants' construction of the preemption and savings clauses. That construction would permit the states to regulate those areas of the insurer-insured relationship that states have traditionally regulated—for example, matters concerning the solvency, reliability, and

ethical conduct of the insurer—while not permitting the states to mandate health benefits whenever an ERISA plan purchases insurance. The latter form of state regulation was unknown when the savings clause was first included by Congress in the bills that ultimately led to ERISA.

B. Proceedings Below

This case began in June 1979, when appellee sued in state court for (i) a declaration that Section 47B can validly be applied to insurance policies sold to ERISA plans and (ii) an injunction directing appellants to comply with the statute. The trial court preliminarily enjoined appellants, during the pendency of the case, to provide the benefits mandated by Section 47B (J.S. App. 71a-84a; A. 57-59).

At trial, defendants stressed that state mandated benefit statutes, such as Section 47B,

(i) make it far more difficult to maintain uniform ERISA plans covering employees in different states;

(ii) significantly increase the cost of plan administration; and

(iii) force plan participants and plan sponsors to choose among (a) paying higher premiums to defray the additional cost of the new, mandated benefit; or (b) sacrificing other benefits that are already covered by the plan and that may well be more desirable than the mandated benefit; or (c) forgoing insurance altogether.

Defendants also observed that mandated benefit statutes improperly induce insured employee benefit plans to drop their insurance and become self-insurers, thus threatening the financial security of ERISA plans.

Notwithstanding these arguments, the Superior Court sustained the validity of Section 47B and granted the injunction sought by the Commonwealth (J.S. App. 36a-62a). Without explanation, the court stated that Section 47B "is not preempted by * * * ERISA" (*id.* at 57a).

On direct appeal, the Supreme Judicial Court of Massachusetts affirmed, although not on the ground advocated by the Commonwealth (J.S. App. 13a-34a). The court rejected appellee's simplistic contention that Section 47B "regulates insurance" and therefore is automatically saved from ERISA preemption by the insurance savings clause. In the court's view, such a literal reading of the savings clause would allow the states to defeat the clear congressional intent to "work a broad preemption" (J.S. App. 21a). The court agreed only that "the language of the savings clause is broad enough to *permit* a construction that would exempt § 47B from preemption" (*id.* at 21a-22a; emphasis added).

As stated in its original decision, the Supreme Judicial Court's prinicipal reason for upholding Section 47B was that the state law deals with the "substantive content" of employee benefit plans, not with the disclosure requirements and fiduciary standards for plan administrators imposed by ERISA. The court explained (J.S. App. 22a; citations and footnote omitted):

> Congress, when it enacted ERISA, was concerned with widespread abuses in plan administration, often resulting in employees' losses of anticipated benefits. In response, Congress enacted rules governing disclosure and fiduciary conduct by administrators of welfare benefit plans. Section 47B has no bearing on the problem of administrative abuse, and does not overlap or interfere with the means chosen by Congress to deal with such abuse. Section 47B affects only the substantive content of plans—a subject completely untouched by ERISA's regulatory

provisions. Therefore, nothing in the practical relationship between the two statutes calls for an implied limitation on the phrase "regulates insurance" that would exclude § 47B from the protection of the savings clause.

The court thus believed that questions of ERISA preemption ultimately can be determined only by considering the extent of actual practical conflict between federal and state law.

Metropolitan and Travelers appealed to this Court, contending that the Massachusetts court erred in permitting its preemption decision to turn on the asserted lack of conflict between Section 47B and the substantive regulations in ERISA. This Court vacated the judgment of the Massachusetts court (J.S. App. 10a-12a), and remanded for reconsideration in light of *Shaw* v. *Delta Air Lines*, *supra*. *Shaw* held that ERISA preemption is broad and does not depend on the existence of conflict between a state statute and federal regulatory provisions. 103 S. Ct. at 2900.

On remand, the Supreme Judicial Court adhered to its earlier decision and rationale (J.S. App. 1a-8a). The court acknowledged that this Court might reach a different result, but it "decline[d] to anticipate such a ruling" (*id.* at 4a). The state court refused to accept *Shaw*'s plain statement that the exceptions to ERISA preemption are "narrow." Instead, it labeled that aspect of the *Shaw* opinion "dictum" and sought to distinguish between the "exemption" from ERISA coverage considered in *Shaw* and the "exception" to ERISA preemption found in the insurance savings clause (*ibid.*).

The Massachusetts court conceded that this Court in *Shaw* rejected the argument that ERISA's broad preemption provision preempts only those state laws that actually conflict with ERISA's substantive regulations (J.S. App. 5a). Nevertheless, the state court held, such a "conflict-based analysis" remains appropriate for interpreting the insurance savings clause (*ibid.*).

The Massachusetts court acknowledged that, in enacting ERISA, Congress intended "to preclude the States from mandating employee benefits" and "to enable interstate employers to maintain uniform plans" (J.S. App. 5a-6a). The court held, however, that this congressional intent "is inconsistent * * * with the broad language of the insurance exception" (*id.* at 6a). Accordingly, the court refused to change its earlier decision and expressly ruled that a state can "mandate employee benefits indirectly through its insurance laws" (*ibid.*).

Justice Wilkins dissented. He took the position that, under *Shaw*, the exceptions to ERISA preemption should be read narrowly, lest a multistate employer be denied the opportunity to maintain a uniform ERISA plan (J.S. App. 8a). Justice Wilkins concluded that Section 47B is not a law that "regulates insurance" within the meaning of ERISA's savings clause. Rather, the dissenting justice wrote, "Section 47B represents precisely that form of local intrusion on ERISA covered benefit plans that ERISA intends to prevent" (*ibid.*).

SUMMARY OF ARGUMENT

This case concerns the proper interaction between ERISA's preemption clause and its insurance savings clause. The task is to read both provisions together so as to give effect to each and serve the purposes of Congress in enacting ERISA.

The first important proposition is that ERISA's preemption clause is extremely broad. Congress rejected narrower alternatives and deliberately sought to occupy the regulatory field fully. ERISA preemption extends beyond the subjects actually regulated by the federal statute and does not depend on a showing of conflict with a federal regulatory provision. These points have already

been established by decisions of this Court. *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981); *Shaw* v. *Delta Air Lines*, 103 S. Ct. 2890, 2899-2901 (1983).

The corollary is that the exceptions to ERISA preemption are narrow. Congressional sponsors of the Act in both the House and Senate made this point explicitly, and this Court confirmed it in *Shaw*. 103 S. Ct. at 2903. The insurance savings clause is one of these narrow exceptions.

Appellee would have the insurance exception swallow the preemption rule. If appellee's position were accepted, states could dictate the entire content of insured ERISA plans, through the simple expedient of prescribing the content of insurance policies that the plans could purchase. The states would thus be able to accomplish indirectly what they clearly are prohibited from accomplishing directly, *i.e.*, regulation of the content of ERISA plans. That is just the sort of indirect regulation that this Court refused to permit in *Alessi*. 451 U.S. at 525.

Moreover, if mandated benefit statutes like Section 47B are not preempted, they will increase costs and severely hamper the efforts of multistate employers to maintain uniform ERISA plans. They will also override the decisions of employers and employees and force plans to choose either increased costs, or abandonment of desired benefits, or surrender of the security of insurance. Each of these alternatives is inconsistent with the congressional scheme reflected in ERISA.

Congress sought to foster uniformity of multistate ERISA plans, as this Court explicitly held in *Shaw*. 103 S. Ct. at 2904 & n.25. Moreover, Congress chose to leave benefit selection to private determination by ERISA plan participants. *Id.* at 2897; *Alessi* v. *Raybestos-Manhattan, Inc.*, *supra*, 451 U.S. at 511.

Finally, Congress never intended to encourage ERISA plans to shift away from insurance. ERISA makes clear that no distinction is to be drawn between uninsured plans—which appellee concedes it cannot regulate—and insured plans. Such a distinction undermines the statutory purpose since it induces plans to have less financial security and thus places at risk the very benefit payments Congress sought to protect.

None of this is disputed. There remains, however, the language of the insurance savings clause. Congress saved from preemption "any law of any State which regulates insurance * * *." Massachusetts stresses this provision and argues that whatever the consequences may be, state laws such as Section 47B must survive. The savings clause, however, cannot be read as broadly as Massachusetts would read it, because such a reading would effectively read the preemption clause out of ERISA and would run directly counter to Congress' purposes in enacting the statute.

To give vitality to both the savings clause and the preemption clause, the former should be construed to refer to the wide variety of traditional forms of state insurance regulation, which are designed to protect the insurance purchaser from overreaching or excessive risk-taking by insurance carriers. These state laws govern such matters as the licensing and examination of insurance brokers and agents, the sales and advertising practices of insurers, the nature of permissible insurance company investments, and the level of reserves needed to guarantee insurance companies' solvency.

State laws of this kind—not laws intended to force ERISA plans purchasing insurance to provide certain specified benefits to plan participants—were doubtless what Congress had in mind when the savings clause was drafted. The savings clause appears in ERISA's predecessor bills at least as early as 1970, and we have found no mandated benefit statute enacted before 1971.

There is no evidence that Congress ever considered such statutes.

By interpreting the savings clause to cover traditional forms of state regulation, but not to permit state determination of the benefits to be provided by insured ERISA plans, appellants would give substantial effect to both the savings clause and the preemption clause. That is a far more rational way of reconciling the two provisions than by allowing the states to evade the preemption clause and regulate the most important aspect of an ERISA plan.

ARGUMENT

I. ERISA PREEMPTION IS UNUSUALLY BROAD, AND THE EXCEPTIONS TO PREEMPTION ARE NARROW

There can be no question concerning the breadth of ERISA's preemption clause. It is a "virtually unique preemption provision." *Franchise Tax Board* v. *Construction Laborers Vacation Trust*, 103 S. Ct. 2841, 2854 n.26 (1983). The clause's language, its history, and its construction by this Court establish that it is as broad as the English language permits. Appellee does not contend otherwise.

Although this issue is settled, we nevertheless review the reasons for construing the preemption clause so broadly. We do so because the scope of any exception to preemption—such as the savings clause—cannot be determined in a vacuum. The proper determination of this case requires reading the preemption and savings clauses together to give each vitality and fulfill the legislative purpose.

A. The Special Breadth of ERISA Preemption

1. *The language of the statute*

Section 514(a) of ERISA provides that the federal statute "shall supersede any and all state laws insofar as

they may now or hereafter relate to any employee benefit plan * * *." This is extremely broad language. The use of the phrase "relate to" reveals a congressional desire to sweep broadly and to cover all state laws having any connection, association, or reference to employee benefit plans.

2. *The legislative history of the preemption clause*

The breadth of ERISA's preemption clause is reinforced by the statute's legislative history. During the legislative consideration of the bills that led to ERISA's enactment, the House and Senate each passed preemption provisions that were substantially narrower than Section 514(a) as it appears today. Both the House and the Senate provisions provided that a state law would be preempted only if it related to subjects actually regulated by the federal statute; in effect, preemption was to require a conflict between federal and state law. The House provision referred to

> any and all laws of the States * * * insofar as they may now or hereafter relate to the reporting and disclosure responsibilities, and fiduciary responsibilities of persons acting on behalf of any employee benefit plan * * * [or] to the nonforfeitability of participant's benefits in employee benefit plans * * *, the funding requirements for such plans, the adequacy of financing of such plans, portability requirements for such plans, or the insurance of pension benefits under such plans.

120 Cong. Rec. 4742 (1974). The Senate provision stated that the new act would "supersede any and all laws of the States * * * insofar as they may now or hereafter relate to the subject matters regulated by" federal law. *Id.* at 5002.

When the House and Senate bills went to conference, the Conference Committee rejected both versions and, in their stead, substituted what is now ERISA's preemption provision. The Committee's report indicated that the sub-

stitution was intended to broaden the preemption provisions in the House and Senate bills and to cover the full range of state laws that "relate to" any employee benefit plan. H.R. Conf. Rep. No. 1280, 93d Cong., 2d Sess. 383, reprinted in 1974 U.S. Code Cong. & Ad. News 4639, 5162.

The comments in the Conference Committee report were reaffirmed when the bill that emerged from conference was considered on the floor of the House and the Senate. Sponsors of the bill stressed the broad preemption provision and the rationale for the Conference Committee's action. They emphasized the provision's role in accomplishing important purposes of ERISA: promoting solvency and permitting plans to operate on a uniform basis throughout the nation.

For example, Representative Dent, one of the bill's sponsors and Chairman of the Subcommittee on Labor of the House Labor and Education Committee, explained:

> Finally I wish to make note of what is to many the crowning achievement of this legislation, the reservation to Federal authority [of] the sole power to regulate the field of employee benefit plans. With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation. * * *
>
> The conferees, with the narrow exceptions specifically enumerated, applied this principle in its broadest sense *to foreclose any non-Federal regulation of employee benefit plans.* Thus, the provisions of section 514 would reach any rule, regulation, practice or decision of any State * * * which would affect any employee benefit plan * * **.

120 Cong. Rec. 29197 (1974) (emphasis added).

Likewise, Senator Williams, another sponsor of the bill and Chairman of the Senate Committee of Labor and Public Welfare, stated:

> It should be stressed that with the narrow exceptions specified in the bill, the substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans. This principle is intended to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of law.

120 Cong. Rec. at 29933.

The legislative history of Section 514(a), therefore, leaves no doubt that Congress sought to enact an extremely broad preemption provision, one that would "foreclose any non-Federal regulation of employee benefit plans." 120 Cong. Rec. 29197 (1974) (remarks of Rep. Dent).

3. The relation of the preemption clause to ERISA's purpose

As the comments of ERISA's legislative sponsors make clear, one of the congressional goals underlying ERISA was to relieve employee benefit plans of the burden of having to comply with varying regulations of the several states. This was essential, in Congress' view, to facilitate the maintenance of uniform multistate plans. The preemption provision was intended to help accomplish this end. As Representative Dent explained, only a broad provision, fully occuping the regulatory field, could "eliminat[e] the threat of conflicting and inconsistent State and local regulation." 120 Cong. Rec. 29197 (1974). Senator Javits, the ranking minority member of the Senate Committee and one of the bill's principal proponents, was even more explicit. He stated that broad preemption was required, to serve "the interests of uniformity with respect to interstate plans * * *." *Id.* at 29942.

Because ERISA's preemption provision was intended to avoid the possibility of subjecting employee benefit plans to conflicting regulations of several states, Congress chose not to tie the preemption clause to ERISA's substantive provisions. *Shaw* v. *Delta Air Lines*, 103 S. Ct. 2890, 2900 (1983). Preemption under ERISA does not depend on whether a state law involves subjects that ERISA itself regulates. It depends only on whether a state law "relates to" employee benefit plans. *Ibid.*

That is precisely the significance of the Conference Committee's rejection of the House and Senate preemption provisions in favor of a broader provision not bounded by the substantive content of ERISA. As shown above (see page 13, *supra*), the House and Senate provisions tied preemption directly to the subjects treated in the proposed federal statute. The Conference Committee rejected this approach, and instead adopted a provision that preempts any and all state laws that relate to employee benefit plans. Conflict with a federal regulatory provision is thus not a prerequisite for ERISA preemption of state law.

4. *This Court's decisions in* Alessi *and* Shaw

The Court has addressed ERISA's preemption clause on two previous occasions, and both times the Court has emphasized the clause's comprehensive character. In *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981), the Court held that by enacting ERISA's broad preemption clause, Congress "meant to establish pension plan regulation as exclusively a federal concern." The Court elaborated on the point two years later, in *Shaw* v. *Delta Air Lines, supra.*

Shaw held that "[t]he breadth of § 514(a)'s preemptive reach is apparent from that section's language. A law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." 103 S. Ct. at 2899-2900 (footnote

omitted). As the Court observed in *Shaw*, referring to the legislative history canvassed above, "Congress used the words 'relate to' in § 514(a) in their broad sense" *Id.* at 2900. The preemptive scope of Section 514(a), the Court said, is "as broad as its language." *Id.* at 2901.

The Court expressly noted the Conference Committee's rejection of the conflict-based preemption provisions originally proposed and its adoption of a broader substitute. 103 S. Ct. at 2900-2901. In view of the Committee's deliberate expansion of ERISA preemption beyond those subjects directly regulated by the new statute, the Court held that Section 514(a) cannot "be interpreted to preempt only state laws dealing with the subject matters covered by ERISA—reporting, disclosure, fiduciary responsibility, and the like." *Id.* at 2900. It is thus well established that ERISA preemption does not depend on whether a state law conflicts with ERISA's regulatory provisions. The appropriate inquiry is simply whether the law "relates to" employee benefit plans. In holding otherwise, the decision below is plainly wrong.

5. *Decisions of the lower federal courts*

If any further support for the breadth of ERISA's preemption is needed, it can readily be found in a large number of decisions by the lower federal courts, both before and after *Shaw*. See, *e.g.*, *Champion International Corp.* v. *Brown*, 731 F.2d 1406, 1408-1409 (9th Cir. 1984); *Russell* v. *Massachusetts Mutual Life Insurance Company*, 722 F.2d 482, 487 (9th Cir. 1983), cert. granted, 105 S. Ct. 81 (1984); *Stone and Webster Engineering Corporation* v. *Ilsley*, 690 F.2d 323, 328-329 (2d Cir. 1982), aff'd, 103 S. Ct. 3564 (1983); *Azzaro* v. *Harnett*, 414 F. Supp. 473, 474 (S.D.N.Y. 1976), aff'd, 553 F.2d 93 (2d Cir.), cert. denied, 434 U.S. 824 (1977); *Hewlett-Packard Co.* v. *Barnes*, 425 F. Supp. 1294, 1298-1300 (N.D. Cal. 1977), aff'd, 571 F.2d 502 (9th Cir.),

cert. denied, 439 U.S. 831 (1978); *National Carriers' Conference Committee* v. *Heffernan*, 454 F. Supp. 914, 917 (D. Conn. 1978). All of these cases establish that Congress sought to occupy the regulatory field fully and to leave no room for supplementary state regulation.

Moreover, the lower federal courts have recognized that ERISA preemption does not depend on the substantive scope of the federal statute. See, *e.g.*, *Bucyrus-Erie Company* v. *Department of Industry, Labor and Human Relations*, 599 F.2d 205 (7th Cir. 1979), cert. denied, 444 U.S. 1031 (1980); *Pervel Industries* v. *Connecticut Commission on Human Rights and Opportunities*, 468 F. Supp. 490 (D. Conn. 1978), aff'd, 603 F.2d 214 (2d Cir. 1979), cert. denied, 444 U.S. 1031 (1980). As Judge Sprecher wrote for the court of appeals in *Bucyrus-Erie*, "we do not think [Section 514(a)] can properly be limited to preempt only those state laws which are specifically related to employee benefit plans or which only relate to these plans by imposing requirements inconsistent with ERISA." 599 F.2d at 209. Likewise, in *Pervel Industries*, Judge Newman stressed that "Congress made a clear-cut decision not to identify various subjects on which state laws were to be preempted, but instead sought to avoid constant litigation over the scope of preemption by preempting, with certain specific exceptions, 'all' state laws insofar as they 'relate' to plans covered by ERISA." 468 F. Supp. at 492.

B. The Narrowness of the Exceptions to ERISA Preemption

The natural corollary of the breadth of ERISA's preemption clause is the narrowness of the exceptions to that clause. Here, too, the legislative history and this Court's prior consideration of the question foreclose fair dispute.

In describing the final version of Section 514 in floor debate, both Representative Dent and Senator Williams explicitly referred to "the narrow exceptions" specified

in the bill. 120 Cong. Rec. 29197, 29933 (1974). This Court in *Shaw* quoted that language, and stressed the narrowness of the exceptions to ERISA preemption. The Court said that Congress "creat[ed] only very limited exceptions to preemption." 103 S. Ct. at 2903. Similarly, the Court referred to "the combination of Congress' enactment of an all-inclusive pre-emption provision and its enumeration of narrow, specific exceptions to that provision * * *." *Ibid.*

To be sure, this Court's opinion in *Shaw* dealt specifically with statutory provisions other than the insurance savings clause.[7] But that does not mean, as the Massachusetts court asserted, that the Court's reference to the narrowness of the exceptions to ERISA preemption was dictum. Nor does it provide any justification for the Supreme Judicial Court's proposed distinction between "exemptions" from ERISA coverage and "exceptions" to ERISA preemption (J.S. App. 4a).

Both "exemptions" from ERISA coverage and "exceptions" to ERISA preemption have the same effect; they define the limited areas of permissible state regulation of employee benefit plans. This Court in *Shaw* reviewed the entire statutory scheme and concluded that ERISA's broad preemption contemplates only a few narrow exceptions. 103 S. Ct. at 2899-2906. The Court specifically spoke in terms of "exceptions" (*id.* at 2899, 2902, 2903); it did not attach any significance to the semantic distinction drawn by the Massachusetts court.

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[7] In particular, *Shaw* construed Section 4(b)(3) of ERISA, 29 U.S.C. 1003(b)(3), which exempts from coverage under the federal law "any employee benefit plan * * * maintained solely for the purpose of complying with applicable * * * disability insurance laws," and Section 514(d) of ERISA, 29 U.S.C. 1144(d), which provides that nothing in the statute shall "be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States * * *."

This Court's analysis of the breadth of ERISA preemption and the narrowness of the exceptions to that preemption was an integral part of the reasoning that led to the Court's holding with respect to the New York Human Rights Law in *Shaw*. The State attempted to defend that law by relying on Section 514(d) of ERISA and arguing that preemption of the Human Rights Law would impair a law of the United States, namely, Title VII of the Civil Rights Act of 1964. In deciding how broadly to construe Section 514(d)'s prohibition against impairment of federal laws, this Court was obliged to determine the proper scope of ERISA preemption and the proper role of the exceptions to that general rule. Far from dictum, the portions of the *Shaw* opinion quoted above represent this Court's definitive assessment of the interaction between ERISA's preemption provision and the limited number of qualifications created by Congress.

II. MANDATED BENEFIT STATUTES LIKE SECTION 47B UNDERMINE CONGRESSIONAL INTENT AND CANNOT BE RECONCILED WITH ERISA'S PREEMPTION SCHEME

Mandated benefit statutes like Section 47B are inconsistent with ERISA's broad preemption provision and undermine congressional intent in several respects. First, mandated benefit statutes would permit states to dictate the substantive content of insured employee benefit plans, notwithstanding Congress' clear decision to remove the states from the regulatory scheme. Second, by allowing precisely the kind of multiplicitous, potentially conflicting state regulation that ERISA's preemption provision was designed to avoid, mandated benefit statutes severely handicap efforts by employers and employees to maintain uniform interstate benefit plans. Third, mandated benefit statutes improperly override private choice regarding the content of ERISA plans, notwithstanding the congressional decision to leave such matters to the private sector. Finally, as already noted,

mandated benefit statutes tend to encourage employee benefit plans to become self-insurers, because that is the only way in which such plans can avoid state interference with their substantive content. This alternative, however, threatens the financial security of ERISA plans and jeopardizes the payment of benefits to employees and their dependents. We consider each of these problems in turn.

A. The Effective Nullification of ERISA's Preemption Clause

It is undisputed that ERISA's preemption clause prevents states from directly dictating the content of employee benefit plans. That is why Massachusetts has not sought to enforce Section 47B to the extent it applies directly to ERISA plans. It is also true, however, that if Section 47B is sustained, Massachusetts and other states will be able to prescribe, with as much detail and specificity as the state legislatures choose, the entire benefit package to be provided by insured employee health plans. Indeed, under the holding below and under the reasoning of appellee, state regulation could go far beyond the benefit package.

Mandated benefit statutes represent an attempt by the states to do indirectly what they are precluded from doing directly. That is contrary to this Court's ruling in *Alessi*. *Alessi* invalidated a New Jersey workers' compensation law on the ground that its prohibition against reducing pension plan benefits by amounts received as workers' compensation was inconsistent with the congressional decision in ERISA to leave the matter to private determination and thus to allow such "integration" of benefits. The case held that ERISA preemption extends even to state laws that seek to regulate employee benefit plans indirectly. The Court stated: "[E]ven indirect state action bearing on private pensions may encroach upon the area of exclusive federal concern" (451 U.S. at 525).

Here, Massachusetts plainly intended to regulate the content of employee benefit plans. Materials prepared by the Massachusetts legislature in connection with Section 47B show that the statute's purpose was to make mental health care more readily available to all state residents, and to increase the revenues recoverable by the Commonwealth for that care. General Court Joint Committee on Insurance, *Advances in Health Insurance in Massachusetts* (August 1974), reprinted in A. 426-468, and summarized in J.S. App. 52a-53a. The statutory provision governing health insurance policies was merely one means to that end; the Commonwealth was seeking to improve access to mental health care, not to regulate insurance.

Section 47B is addressed explicitly to employee benefit plans, not merely to insurance policies. By ignoring the portion of the statute that is concededly unenforceable and defending the remainder as if it were a simple insurance statute, appellee seeks to justify state control over the benefits provided by insured plans. Appellee is thus trying to accomplish indirectly what it cannot accomplish directly. That is exactly what this Court refused to permit in *Alessi*.

With respect to insured plans, appellee's argument here means that the result reached in *Alessi* could actually be reversed through action by a state legislature. A state law could require that an insurance policy covering an employer's workers' compensation obligations contain a provision forbidding the offset of benefits payable under that policy against benefits due to an employee under a retirement or pension plan. Under the reasoning of the Supreme Judicial Court, such a state law would not be preempted by ERISA, even though it would accomplish precisely the result found unacceptable by this Court in *Alessi*.

Because Massachusetts cannot directly compel ERISA plans to provide specific health benefits, it should not be permitted to achieve that result indirectly. As this Court wrote in *Alessi* (451 U.S. at 525), "ERISA's authors clearly meant to preclude the States from avoiding through form the substance of the pre-emption provision."

B. Increased Costs and Difficulties in Maintaining Uniform Multistate Plans

Congress chose the broad preemption approach to foster uniformity and solvency in employee benefit plans. It sought to eliminate the potential for increased costs and regulatory variation arising from state law.

Both ERISA's legislative history and this Court's decision in *Shaw* confirm the point. This Court said that "[b]y establishing benefit plan regulation 'as exclusively a federal concern,' * * * Congress minimized the need for interstate employers to administer their plans differently in each State in which they have employees." 103 S.Ct. at 2904, quoting *Alessi* v. *Raybestos-Manhattan, Inc.*, *supra*, 451 U.S. at 523. See also the comments of ERISA's sponsors at pages 14-15, *supra*.

Following *Shaw*, other federal courts have acknowledged the congressional purpose to encourage uniformity among multi-state plans. See, *e.g.*, *Champion International Corp.* v. *Brown*, *supra*, 731 F.2d at 1409; *Russell* v. *Massachusetts Mutual Life Insurance Company*, *supra*, 722 F.2d at 487 ("the broad preemptive language of section [514 was] intentionally designed to provide complete protection to plan funds and participants by establishing national uniformity in the regulation of employee benefit plans"). See also *Stone and Webster Engineering Corp.* v. *Ilsley*, *supra*, 690 F.2d at 329. As Senator Javits said, ERISA preemption was designed to advance "the interests of uniformity with respect to interstate plans * * *." 120 Cong. Rec. 29942 (1974).

The court below agreed that Congress intended "to preclude the states from mandating employee benefits" (J.S. App. 6A). Nevertheless, the court decreed, that intent "is inconsistent * * * with the broad language of the insurance exception." (*Ibid.*) For this reason, the state court declined to find preemption, even though that decision clearly diminished the ability of multistate employers to maintain uniform ERISA plans. The court thus subordinated one of Congress' principal goals in ERISA—encouraging uniform interstate plans—to a provision of the Act that was intended merely to provide a narrow exception to the preemption rule.[8]

If mandated benefit statutes are sustained, nationwide plans seeking uniformity will have only two alternatives: either give up insurance altogether or adopt a single national policy that, at vastly increased expense, provides for all employees the most generous of each of the mandated benefits required by one or more states (assuming, of course, that no such minimum requirements conflict with each other). One law review article has described this dilemma very well:

> If states are permitted to require employee benefit plans to provide substantive benefits under the guise of insurance regulation, the result may be a Hobson's choice for employer or labor and management negotiators: either abandon the funding of benefit plans through insurance policies or be willing to accept all-encompassing uniform national contracts. For if each state may impose its own substantive terms on the plan, the only way uniformity may be reached is by incorporating into the plan all of the benefits each state requires. This dilemma is clearly of the type that Congress sought to avoid by enacting ERISA's preemption provisions, which were formulated to relieve interstate employee benefit plans of the adverse effects of cumulative or inconsistent state regulation.

Hutchinson and Ifshin, *Federal Preemption of State Law Under the Employment Retirement Income Security Act of 1974*, 46 U. Chi. L. Rev. 23, 68-69 (1978).[9]

Shaw reached an identical conclusion in the context of the state fair employment laws that were directly at issue there. The extended discussion in note 25 of this Court's opinion closely parallels the academic comments reproduced above (*see* 103 S. Ct. at 2904 n.25). Because of the significance of this point, we reproduce the Court's footnote in full:

> An employer with employees in many States might find that the most efficient way to provide benefits to those employees is through a single employee benefit plan. Obligating the employer to satisfy the varied and perhaps conflicting requirements of particular state fair employment laws, as well as the requirements of Title VII, would make administration of a uniform nationwide plan more difficult. The employer might choose to offer a number of plans, each tailored to the laws of particular States; the inefficiency of such a system presumably would be paid for by lowering benefit levels. Alternatively, assuming that the state laws were not in conflict, the employer could comply with the laws of all States in a uniform plan. To offset the additional expenses, the employer presumably would reduce wages or eliminate those benefits not required by any State. Another means by which the employer could retain its uniform nationwide plan would be by eliminating classes of benefits that are subject to state requirements with which the employer is unwilling to comply. ERISA's comprehensive pre-emption of state

[8] As we show at pages 34-36, *infra*, the savings clause can be construed to protect broad areas of state regulation, without effectively nullifying the preemption clause.

[9] The Hutchinson and Ifshin article was cited with approval in this Court's opinion in *Shaw*. 103 S.Ct. at 2901 n.19.

law was meant to minimize this sort of interference with the administration of employee benefit plans.

Shaw thus provides strong support for appellants' position in the present case. The Congress that tried to encourage uniformity and promote solvency could hardly have intended that the only means of accomplishing that end would be either self-insurance or comprehensive compliance with all the various and shifting positions of state legislatures that choose to enact mandated benefit laws.

If a multistate plan does not adopt one of the foregoing alternatives, Section 47B and other mandated benefit statutes will produce disparate treatment of employees covered by the same health plan, depending on the state in which they reside. Plainly, as footnote 25 in *Shaw* observes, this would entail substantial administrative expense. A senior employee responsible for administering General Electric's ERISA plan testified that mandated benefit statutes could increase General Electric's annual administrative costs by $25 million (A. 115-116), and the trial court expressly found that "[m]andated benefit laws do impose an administrative burden" (J.S. App. 54a).

Moreover, the disparate treatment of employees of a single employer, perhaps working at a single plant, is bound to produce serious practical problems. Consider, for example, an employer's insured health plan, covering employees at a single plant, some living in Massachusetts and some living in Rhode Island. The plan would be required to provide minimum coverage for the treatment of the mental and nervous conditions of the Massachusetts residents, but no such coverage would be required for the Rhode Island residents. As the trial testimony of an experienced administrator of ERISA plans showed (A. 81), such inequalities inevitably lead to employee dissatisfaction and complaints about the benefit plan. The

problems thus created are particularly acute for employers with many employees whose jobs require them to move frequently from one state to another.

C. Overriding Private Choice

Another important aspect of the congressional scheme underlying ERISA was the decision to leave the substantive content of employee welfare and pension plans to private determination. The legislative history on this point is clear, as we show below. Moreover, in both *Alessi* and *Shaw*, this Court noted Congress' decision to leave benefit selection to private choice. See 451 U.S. at 511; 103 S. Ct. at 2897. Neither appellee nor the court below has disputed the point.

Mandated benefit statutes like Section 47B, however, displace the private choices of an ERISA plan's participants and sponsors. They impose added costs and require that plan participants either agree to increased premiums or sacrifice one or more benefits already included in their ERISA package. Either way, private choice is overridden, and employees' reasonable expectations are disappointed.[10]

ERISA was largely motivated by the congressional desire to avoid abuses in employee pension plans. Through

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[10] The trial testimony of James M. Dawson, the administrator of several craft union health and welfare funds, provided a specific example of this situation. Referring to one of the funds he administers, Mr. Dawson testified that because of a state mandated benefit statute, union members "felt they could not afford to pay for the benefits required by that statute and still keep all the benefits they had in their own particular plan" (A. 76). The net result, Mr. Dawson testified, was that the union members were compelled to make eligibility for plan benefits more restrictive and to "eliminate[] all vision and dental care under their package in order to meet the requirements of the state mental health law" (A. 76-77). This caused great dissatisfaction among the members, who wished to retain visual and dental benefits and to liberalize eligibility for coverage under the plan, and who did not want to pay for expanded mental health coverage (A. 77-78).

several years of study and investigation, Congress had learned of pension plan abuses in which employee benefits were lost because of very restrictive vesting rules, or inadequate plan funding, or employer bankruptcies. Congress sought to remedy these problems in ERISA. It did so by enacting detailed provisions concerning the vesting of pension rights, the funding for pension plans, the requirement for insurance against plan termination, disclosure of pension plan provisions, the fiduciary responsibility of pension plan administrators, and the portability of pension plan rights. By these means, Congress sought to ensure that pension benefits earned would actually be realized. See, *e.g.*, 120 Cong. Rec. 29192 (1974) (remarks of Rep. Perkins); *id.* at 29944 (remarks of Sen. Javits).

Congress did not, however, require employers to maintain pension plans, and it did not prescribe the kind of benefits that pension plans must provide. Those matters were left to private decision. Throughout the consideration of ERISA, Congress was acutely aware of the need to avoid making pension plan administration so burdensome that it would significantly diminish the likelihood that employers would offer pension plans. The Senate Committee Report, for example, stated:

> The Committee believes that the legislative approach of establishing minimum standards and safeguards for private pensions is not only consistent with retention of the freedom of decision-making vital to pension plans, but in furtherance of the growth and development of the private pension system. * * *
>
> The Bill reported by the Committee represents an effort to strike an appropriate balance between the interests of employers and labor organizations in maintaining flexibility in the design and operation of their pension programs, and the need of the workers for a level of protection which will adequately protect their rights and just expectations.

S. Rep. No. 127, 93d Cong., 1st Sess. 13 (1973), reprinted in 1974 U.S. Code Cong. & Ad. News 4849-4850. It was thus absolutely clear at all times that the decision to offer pension plans and the substantive content of such plans were completely left to bargaining between employers and employees.

This Court has already recognized the point. Referring to the content of benefits provided under ERISA pension plans, the Court held in *Alessi* that "ERISA leaves this question largely to the private parties creating the plan." 451 U.S. at 511. In the Court's words, "the private parties, not the Government, control the level of benefits * * *." *Ibid.*

A recent Sixth Circuit decision provides further support for the importance of private choice. In *Moore* v. *Reynolds Metals Company Retirement Program For Salaried Employees*, 740 F.2d 454, 456 (6th Cir.), pet. for cert. filed, No. 84-740 (Nov. 3, 1984), the court of appeals stressed that "an employer has no affirmative duty to provide employees with a pension plan. In enacting ERISA, Congress continued its reliance on *voluntary* action by employers" (emphasis in original, citation omitted).

The point applies to employee health plans as well as pension plans. ERISA draws no distinction in this regard. As this Court noted in *Shaw* in the context of ERISA health plans, "ERISA does not mandate that employers provide any particular benefits * * *." 103 S. Ct. at 2897. The substantive content of health plans, like pension plans, was left to private parties.

Although Congress decided that neither it nor the states should be involved in the business of dictating plan benefits, mandated benefit statutes like Section 47B overrule the choices of the private sector and subject the content of employee benefit plans to public control. The states should not be permitted to circumvent the congressional decision in the guise of regulating insurance.

D. The Tendency to Encourage Self-Insurance

If the decision below stands, there will be only one way for ERISA plans to avoid the effect of mandated benefit statutes. They can forgo insurance and become self-insurers.

ERISA itself, however, draws no distinction between insured and uninsured plans. On the contrary, Section 3(1) of the Act, 29 U.S.C. 1002(1), explicitly includes within the definition of "employee welfare benefit plan" plans that provide benefits "through the purchase of insurance or otherwise."

By imposing additional burdens on insured plans only, mandated benefit statutes provide an incentive for plans to forgo the purchase of insurance policies and to establish their own funds for the payment of employee benefit claims. The more onerous the benefits mandated by state laws, the greater the administrative and premium costs they impose, and the greater the incentive for employee health plans to forgo insurance. This will skew the financial support of employee benefit plans in a way never intended by Congress, will threaten the plans' financial security, and will increase the likelihood that individual plans will not have sufficient funds available to fulfill their obligations to sick or injured employees.[11]

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[11] In fact, as mandated benefit statutes have proliferated, the number of self-insured employee benefit plans has grown dramatically. Munnelli, *Administrative Services Contracts*, 17 The Forum 987, 987 (1982). It is, at the least, a reasonable inference that these statutes have contributed to this trend. Uncontradicted testimony supporting this inference, and pointing out the relationship between mandated benefit costs and the attractiveness of self-insurance, was given by three trial witnesses. A. 83-85, 117, 189-191.

The experience of appellant Metropolitan is also instructive. In 1975, claims paid to beneficiaries of self-insured plans (for which Metropolitan provided only administrative services) amounted to approximately $20 million or 1.2% of the total group health claims paid by Metropolitan during that year. By 1983, the annual dollar figure for self-insured plans administered by Metropolitan had grown to more than $740 million, and these claims represented 15.2% of all group health claims paid by the company.

Moreover, the incentive toward self-insurance tends irrationally to favor large employee plans over small. Large plans are the ones more likely to have the funds necessary to take advantage of the self-insurance option, and thereby to avoid the cost of mandated benefits. Smaller plans, on the other hand, will be forced to purchase insurance and to bear the additional costs that mandated benefit laws entail.

Nothing whatsoever in the language or legislative history of ERISA suggests that Congress intended to make the states' power to regulate the substantive content of employee benefit plans turn on the size of the plan, or the plan's willingness or capacity to be a self-insurer. These factors bear no rational relationship to the legislative concerns underlying ERISA. The distinction produced by the Commonwealth's application of Section 47B and endorsed by the decision below therefore is inappropriate.

III. ALTHOUGH THE INSURANCE SAVINGS CLAUSE DOES NOT PERMIT THE STATES TO MANDATE THE BENEFITS PROVIDED BY ERISA PLANS, IT DOES PLAY A SIGNIFICANT ROLE IN THE STATUTORY SCHEME

We have demonstrated substantial inconsistencies between mandated benefit statutes on the one hand and ERISA's statutory purposes and preemption scheme on the other. Massachusetts does not really dispute these inconsistencies, but it argues that the insurance savings clause nevertheless protects Section 47B. We turn then to the proper interpretation of the savings clause, considered in the context of ERISA's broad preemption provision and Congress' purposes in enacting the statute. Three possible interpretations have been proposed in this case.

A. The Commonwealth's Position

First, the Commonwealth has argued that because Section 47B purports to regulate insurance, it is automatically protected from preemption by the savings clause. The Commonwealth simply points to the statutory words "any law of any State which regulates insurance" and rests its case. This literalistic approach was rejected by the Supreme Judicial Court in its earlier decision (J.S. App. 21a-22a), and was not even mentioned in the opinion on remand. It is an overly simple, mechanical approach that would permit the states to engage in virtually unlimited regulation of ERISA plans, as long as they couch their actions in terms of insurance regulation.

Prior to the decision in *Alessi*, the First Circuit sustained a New Hampshire statute similar to Section 47B, basically adopting the position now advocated by Massachusetts. *Wadsworth* v. *Whaland*, 562 F.2d 70 (1st Cir. 1977), cert. denied, 435 U.S. 980 (1978).[12] The decision in *Wadsworth* is unpersuasive essentially for the same reasons that the arguments of Massachusetts are unpersuasive. Both would permit the insurance exception to override the preemption rule. That cannot have been Congress' intent.[13]

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[12] Two other state courts have reached similar decisions. See *Metropolitan Life Insurance Co.* v. *Whaland*, 119 N.H. 894, 410 A.2d 635 (1979); *Insurance Commissioner* v. *Metropolitan Life Insurance Co.*, 296 Md. 334, 463 A.2d 793 (1983).

[13] The court of appeals in *Wadsworth* also devoted attention to the so-called "deemer" clause in Section 514(b)(2)(B) of ERISA, which provides that an employee benefit plan shall not "be deemed to be an insurance company or other insurer, * * * or to be engaged in the business of insurance * * * for purposes of any law of any State purporting to regulate insurance companies, [or] insurance contracts * * *."

Although the deemer clause does not directly address the proper interpretation of the insurance savings clause, it does provide some guidance here. It shows that Congress did not want states to avoid preemption through an overly broad construction of the savings clause. The deemer clause was obviously intended to prevent states from circumventing ERISA preemption by treating ERISA plans as insurers and using that ploy as a justification for state regulation of such plans. Similarly, the savings clause should not be interpreted to permit the states to use the pretext of "insurance regulation" as a means of dictating the benefits to be provided by ERISA plans.

B. The Supreme Judicial Court's Approach

Having rejected the Commonwealth's position, the Supreme Judicial Court offered a second possible interpretation of the insurance savings clause. The court held that a state law purporting to regulate insurance will not be preempted unless it conflicts with ERISA's substantive provisions. The court thus tried to resolve the tension between the rule and the exception by deferring in all cases to the exception, absent a showing that such deference would raise a direct conflict with ERISA's regulatory provisions.

This approach is contrary to the well-established principle that ERISA preemption does not depend on conflict with ERISA's regulatory provisions. *Shaw* v. *Delta Air Lines, supra*, 103 S. Ct. at 2900. That was precisely the kind of test that Congress rejected when the Conference Committee adopted its substitute for the earlier preemption proposals of the House and the Senate. Those proposals were explicitly tied to "the subject matters regulated by" the new federal law. See page 13, *supra*. Congress replaced them with the much broader provision in Section 514(a). There is no justification for disregarding this fundamental feature of ERISA's preemption clause, merely because one of the narrow exceptions to that clause is arguably implicated.

As Justice Wilkins correctly recognized in dissent below, "Congress has adopted an all-inclusive preemption scheme, and it is now clear, in light of the *Shaw* opinion, that it is irrelevant whether State law dictating plan benefits conflicts with the substantive policies of ERISA" (J.S. App. 8a).

It is worth noting here that, although the approach followed by the court below purports to be more moderate than that pressed by appellee, it amounts in practice to very much the same thing. ERISA does not regulate the substantive content of employee benefit plans; that much is agreed. Accordingly, by simply mandating particular coverage to be provided, no state statute could possibly conflict with ERISA's regulatory provisions, in the direct sense required by the court below as a precondition for preemption. ERISA does not deal with the subject, and therefore, under the "conflict-based" approach of the court below, as well as under appellee's absolutist approach, the states would be completely free to dictate the content of insured ERISA plans, to overturn the result in *Alessi* (see page 22, *supra*), and to regulate plans in many other ways.

C. Appellants' Proposal for Giving Effect to Both the Preemption Clause and the Savings Clause

There is a third possible interpretation of the savings clause. It would give full effect to the language of the clause, without surrendering to the states the broad regulatory power over employee benefit plans that was denied them by the preemption clause. That is the approach advocated by appellants.

The preemption and savings clauses can be sensibly reconciled by construing the latter to include the wide range of state laws designed to protect the insurance purchaser from improper or imprudent conduct by the insurance company—but not those state laws whose purpose and effect is to control plan content or the relationship between the plan itself and the plan's beneficiaries. The state laws that should be saved from preemption are those falling within the traditional areas of state insurance regulation, such as: the licensing and examination of insurers, agents, and brokers; the specification of standards of conduct for sales and advertising; the prescription of criteria governing investment of funds; mini-

mum capital and surplus requirements; requirements that adequate policy reserves be maintained; the setting of character standards for insurance company management; general oversight of insurance companies by state insurance departments; and regular financial reporting by insurers. Such a construction of the savings clause was recently adopted in *Michigan United Food & Commercial Workers Unions & Food Employers Health & Welfare Fund* v. *Baerwaldt*, 572 F. Supp. 943, 950-952 (E.D. Mich. 1983), appeal docketed, No. 83-1570 (6th Cir. Aug. 16, 1983). See also *Bell* v. *Employee Security Benefit Association*, 437 F. Supp. 382, 391 (D. Kan. 1977) (holding that the "primary purposes of insurance regulation" are to avoid overreaching by insurers, to assure their stability and solvency, and to assure that rates and rate classifications are reasonable and fair). By focusing on the kinds of insurance regulation in which the states have traditionally engaged, this approach permits state regulation in the areas that Congress almost certainly had in mind when it enacted the insurance savings clause. It does so without significantly affecting the operation of ERISA plans.

Although there may be cases in which reconciliation of the preemption clause and the savings clause poses difficult line-drawing problems, this is not such a case. Here, the consequences of accepting appellee's interpretation of the savings clause are so extreme and so inconsistent with ERISA's scheme that there should not be any serious question about the proper accommodation of the two provisions.

It is equally easy to provide examples of state statutes at the opposite end of the spectrum, *i.e.*, laws that plainly should be preserved under the ERISA savings clause. Several recent reported decisions have involved such laws, and appellants' approach would protect them from preemption. See, *e.g.*, *American Progressive Life and Health Insurance Company* v. *Corcoran*, 715 F.2d 784, 785-787

(2d Cir. 1983); *Wayne Chemical, Inc.* v. *Columbus Agency Service Corporation*, 567 F.2d 692 (7th Cir. 1977); and *Brink* v. *DaLesio*, 496 F. Supp. 1350, 1382 (D. Md. 1980), aff'd in part, rev'd in part, and remanded on other grounds, 667 F.2d 420 (4th Cir. 1981).

Among other things, *American Progressive* involved a New York insurance regulation that established a maximum commission for sales of life insurance on a mass merchandising basis to participants in pension funds; *Wayne Chemical* involved an Indiana insurance law forbidding the sale of insurance without a certificate of authority from the state's Commissioner of Insurance; and *Brink* involved a Maryland law that prohibited an insurer from cancelling a policy for non-payment of premiums if the premium due had been paid to the insurance broker. Each of these provisions was sustained against a preemption challenge; each offered protection to the insurance purchaser against possible overreaching by the insurance carrier.

Statutes like those described in the preceding paragraph illustrate the type of insurance regulation that traditionally has been reserved to the states. These statutes do not interfere with the operation of ERISA plans, and they have no effect on the nature or level of benefits offered by such plans. They are thus far different from mandated benefit statutes.[14]

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[14] Although appellants agree that the statutes described in the text are clearly not preempted by ERISA, appellants do not endorse some of the reasoning used by the courts in *American Progressive*, *Wayne Chemical*, and *Brink*. Those cases cite *Wadsworth* with approval and appear to proceed on the assumption that any state law that purports to regulate insurance is automatically saved from preemption. For the reasons already set forth, such an overly broad reading of the savings clause is incorrect. It is not needed to save from preemption the state laws described in the text. Under appellants' approach, these laws, as well as myriad other state statutes that regulate insurance, can be preserved from ERISA preemption, without at the same time surrendering regulation of insured ERISA plans entirely to the states.

We can be quite confident that Congress was not thinking of mandated benefit statutes when it enacted ERISA. As far as we have been able to determine, no such statute existed before 1971. But at least as early as March 1970, the insurance savings clause was already included in the bills that led to ERISA. Congress considered many such bills before ERISA finally was enacted in 1974, and the insurance savings clause was a constant feature in all of them, well before a single mandated benefit statute was enacted by any state.[15] See S. 3589, 91st Cong., 2d Sess. § 14 (1970), reprinted in 116 Cong. Rec. 7280, 7284 (1970); H.R. 16462, 91st Cong., 2d Sess. § 14 (1970), reprinted in 116 Cong. Rec. 7570, 7577 (1970). See also *Private Welfare and Pension Plan Legislation: Hearings on H.R. 1045, 1046, and H.R. 16462 Before the Subcomm. on Labor of the House Comm. on Education and Labor*, 91st Cong., 1st & 2nd Sess. 1, 12 (1976).[16]

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[15] In a footnote in the jurisdictional statement for appellant Metropolitan (84-325 J.S. 24 and n.13), we stated that four states enacted mandated benefit statutes before 1973, "when the insurance savings clause first appeared in the bills that led to ERISA." The statement that the insurance savings clause first appeared in 1973 was in error. That was the time at which the bills that were passed by the House and Senate and sent to the Conference Committee in 1974 were introduced. But predecessor bills had been before Congress for a number of years, and as indicated in the text, the insurance savings clause had made its appearance at least as early as March 1970.

[16] The insurance savings clause appeared in several other bills before ERISA was enacted. See, *e.g.*, S. 2, 92d Cong., 1st Sess. § 507 (1971), reprinted in *Welfare and Pension Plan Legislation: Hearings on H.R. 1269 before the Subcomm. on Labor of the House Comm. on Education and Labor*, 92d Cong., 1st Sess. 84 (1971); *id.* at 15, reprinting H.R. 1269, 92d Cong., 1st Sess. § 114 (1971); S. 3598, 92d Cong., 2d Sess. § 609(a)(2) (1972), reprinted in *Retirement Income Security for Employees Act, 1972: Hearings on S. 3598 before the Subcomm. on Labor of the Senate Comm. on Labor and Public Welfare*, 92d Cong., 2d Sess. 87 (1972); S. 4, 93 Cong., 1st Sess. § 609(a)(2) (1973), reprinted in *Retirement Income Security For Employees Act, 1973: Hearings before the Subcomm. on Labor of the Senate Comm. on Labor and Public Welfare.*

It is hardly surprising then that there is no legislative evidence whatsoever suggesting that ERISA sought to preserve mandated benefit statutes or that Congress even knew about such statutes when it enacted the savings clause. Under these circumstances, there is no justification for adopting a broad construction of the clause that will produce results incompatible with the rest of the statute and with the underlying congressional purposes. The clause should be interpreted to effectuate the overall objectives of ERISA and at the same time to give effect to all the statutory language.

CONCLUSION

The judgment of the Supreme Judicial Court should be reversed.

Respectfully submitted,

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93d Cong., 1st Sess. 96 (1973); H.R. 2, 93d Cong., 1st Sess. § 114 (1973), reprinted in *Welfare and Pension Plan Legislation: Hearings on H.R. 2 and H.R. 462 before the Subcomm. on Labor of the House Comm. on Education and Labor*, 93d Cong., 1st Sess. 15 (1973).

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v.

COMMONWEALTH OF MASSACHUSETTS,
Appellee

THE TRAVELERS INSURANCE COMPANY,
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v.

COMMONWEALTH OF MASSACHUSETTS,
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On Appeal From The Supreme Judicial Court Of The Commonwealth Of Massachusetts

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BRIEF OF THE AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS AS AMICUS CURIAE IN SUPPORT OF APPELLANTS

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BRIEF OF THE AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS AS AMICUS CURIAE IN SUPPORT OF APPELLANTS

The American Federation of Labor and Congress of Industrial Organization ("AFL-CIO") submits this brief *amicus curiae* with the consent of the parties pursuant to the rules of this Court.

INTEREST OF THE AMICUS CURIAE

The AFL-CIO is a federation of 95 national and international labor organizations representing approximately 13,000,000 employees throughout the United States. These unions engage in collective bargaining in an effort to secure for the employees they represent the terms and conditions of employment those employees desire.

It is the experience of the AFL-CIO and of its affiliates that state laws of the type at issue here make that task more, rather than less, difficult by substituting for private decision-making a state-imposed requirement that, if certain benefits are agreed to (here, insurance for hospital and surgical expenses), other benefits must also be provided (here, insurance for treatment of mental illness) regardless of whether the employees desire such benefits or would prefer other benefits (or higher wages) instead. The AFL-CIO submits this brief *amicus curiae* to demonstrate that Congress intended to protect the autonomy of private decision-making with respect to these matters.

SUMMARY OF ARGUMENT

Section 514 of ERISA, 29 U.S.C. § 1144, states the general ERISA preemption rule: the Act "shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan. . ." Standing alone, that section would undoubtedly preempt the portion of the Massachusetts law at issue here for, as the Massachusetts court recognized, the state law "effectively control[s] the content of insured welfare benefit plans" and thus "relate[s] to" such plans. J.S. 20a. And the preemptive force of § 514(a) is enhanced by the federal labor laws which embody an "additional federal interest in precluding state interference with labor-management negotiations." *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981). Part A, pp. 4-6 *infra*.

The court below relied on the ERISA "savings clause" —which provides that "nothing in this subchapter shall

be construed to exempt or relieve any person from any law of any State which regulates insurance. . .," ERISA § 514(b)(2)(A), 29 U.S.C. § 1444(b)(2)(A)—to sustain the Massachusetts law. The court read the key words in that clause—"law . . . which regulates insurance"—to save any statute which, in form, is addressed to insurers and which does not "conflict with the policies or operation of ERISA." J.S. 5a. And the court concluded that the Massachusetts law at issue here is not in conflict with ERISA—and thus is not preempted—because it "affects only the substantive contents of plans." *Id.* 22a.

On its face, the decision below is an implausible construction of the savings clause. Nothing in the language of that clause bespeaks a congressional intent to set the courts at large to determine, on an *ad hoc* basis, which state laws conflict with ERISA's policies. Furthermore, the effect of the decision below is to transform ERISA—which was enacted to "assur[e] the . . . financial soundness" of benefit plans, ERISA § 2(a), 29 U.S.C. § 1001(a) —into a law which places insured plans at a disadvantage as compared to self-insured plans and thereby discourages the use of insurance to fund benefit plans. Part B, pp. 6-10, *infra*.

That is not what Congress intended. The legislative history, which we review in detail, Part C(1), pp. 10-23, *infra*, proves that Congress sought to protect the autonomy of private decisions with respect to the content of benefit plans, and that to the extent regulation was desirable, Congress concluded that uniform regulation was required to accommodate the needs of multi-state plans. Congress also sought to encourage the use of insurance to fund benefit plans. The savings clause—which Congress viewed as a narrow exception to the broad preemption rule of § 514(a)—was not intended effectively to nullify those policies by authorizing state regulation of the contents of insured plans through the form of insurance reglation. Rather, to make sense of the statutory language and policies, the phrase "law . . . which regulates insurance" must be understood to mean a law that both in

form *and in substance* is addressed to the conduct of insurers, and not to the content of benefit plans. Accordingly, the Massachusetts law at issue here falls outside the savings clause and thus is preempted by § 514(a). Part C(2)-(3), pp. 23-27, *infra*.

ARGUMENT

The Massachusetts statute at issue in this case states that "[a]ny blanket or general policy of insurance . . . which provides hospital expense and surgical expense insurance . . . or any employees' health and welfare fund which provides hospital expense and surgical expense benefits . . . shall provide benefits for expense . . . arising from mental or nervous conditions . . ." Mass. Gen. Laws ch. 175, § 47B. It is common ground that, under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C .§ 1001 et seq., a state may not in terms require an employee benefit plan to provide any particular benefits and that therefore insofar as the Massachusetts law applies directly to such plans, the statute is preempted by ERISA. But the Massachusetts Supreme Judicial Court held that under ERISA a state may "effectively control the content of insured welfare benefit plans," J.S. 20a, so long as the state does so "indirectly through its insurance laws," *id.* 6a.

As we proceed to show, that holding is erroneous: ERISA—both standing alone and when read in conjunction with the federal labor laws—precludes the states from controlling the nature and quantum of benefits provided by an employee benefit plans regardless of the form of the state regulation.

A. Section 514 of ERISA, 29 U.S.C. § 1144, is a "virtually unique preemption provision." *Franchise Tax Board* v. *Construction Laborers Vacation Trust*, —— U.S. ——, 51 L.W. 4945, 4952 n.26 (June 24, 1983). Subsection (a) of that section states the general ERISA preemption rule: the Act "shall supersede any and all state laws insofar as they may now or hereafter relate to

any employee benefit plan. . ." "The breadth of § 514(a)'s pre-emptive reach is apparent from that section's language. A law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Shaw* v. *Delta Air Lines, Inc.*, —— U.S. ——, 51 L.W. 4968, 4971 (June 24, 1983).

If § 514(a) stood alone, there would be no doubt that the portion of the Massachusetts law at issue here would be preempted. As the Massachusetts court observed, under the state statute "a plan that purchases insurance has no choice but to provide mental health care benefits" and thus the law "effectively control[s] the content of insured welfare benefit plans." J.S. 20a. Based on that fact, and based upon its reading of *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981)—in which this Court held that § 514(a) preempts a state statute prohibiting set-offs of workers compensation payments against pension benefits—the Massachusetts court concluded that the Massachusetts statute "is a law that 'relate[s] to' benefit plans within ERISA's general preemption clause." J.S. 20a.

Alessi also points to "[a]nother consideration [which] bolsters [this] conclusion." 451 U.S. at 525. As the Court there noted, under the National Labor Relations Act, as amended, there is an "additional federal interest in precluding state interference with labor-management negotiations," *id.*; reading that Act in conjunction with ERISA the *Alessi* Court concluded that it is "federal policy" to assure that employee benefits are "a subject of either labor-management negotiations or federal legislation," *id.* at 526 n.22. The Massachusetts statute at issue here is squarely contrary to that policy.[1]

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[1] It is not at all clear how far the federal policy favoring free collective bargaining, standing alone, would go in preempting state regulation of benefit plans. The NLRA is silent with respect to the issue of preemption, and "the statutory implications of what

B. The Massachusetts court nonetheless sustained the state statute, relying on subsection (b)(2)(A) of ERISA § 514—the "savings clause," 29 U.S.C. § 1144(b)(2)(A). That clause provides, in pertinent part, that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance . . ." The court below held—erroneously as we now show—that insofar as it applies to insured benefit plans the Massachusetts statute is a "law . . . which regulates insurance" within the meaning of that clause.

As the Massachusetts court recognized, the bare words of the savings clause are "of little help" in ascertaining its sweep. J.S. at 22a. That clause could, of course, be read to save from preemption all state statutes which, *in form*, are addressed to an insurance company, regardless of the substance of the statute or its impact on benefit plans. But such a reading would mean that, with re-

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has been taken from the States and what has been left to them are of a Delphic nature . . ." *Machinists* v. *Gonzales*, 356 U.S. 617, 619 (1958). This Court recognized years ago that "[s]tate laws have long regulated a great variety of conditions in . . . industry," and "it cannot be that the minimum requirements laid down by state authority are all set aside" by federal law. *Terminal Ass'n* v. *Trainmen*, 318 U.S. 1, 6-7 (1943). On the other hand, it is equally clear that the states cannot be wholly free to "limit[] the solution that the parties' agreement can provide to the problem of wages and working conditions." *Teamsters Union* v. *Oliver*, 358 U.S. 283, 295-96 (1959). *See also* Brief of the AFL-CIO as *Amicus Curiae* in No. 83-1748, *Allis Chalmers Corporation* v. *Lueck* at pp. 3-6 & n.3.

It is not necessary in this case for the Court to decide where the NLRA, standing alone, would require that the line be drawn between what "has been taken from the States and what has been left to them." *Malone* v. *White Motor Corp.*, 435 U.S. 497, 505 (1978), teaches that, prior to ERISA, the Welfare and Pension Plans Disclosure Act ("WPPDA"), 72 Stat. 997, provided "a far more reliable indicium of congressional intent with respect to state authority to regulate pension plans" than did the NLRA. And the same is now true with respect to ERISA, the successor to the WPPDA. *See also Alessi*, *supra*, 451 U.S. at 526 n.23. At most, then, as in *Alessi*, the NLRA here "bolsters" the conclusion derived from ERISA § 514(a).

spect to insured plans, the states would be free to regulate the very subjects regulated by ERISA, and to do so in a manner inconsistent with ERISA. For example, under that reading of the savings clause a state could, through ostensible insurance regulation, mandate that pensions in insured plans fully vest after an employee completes only five years of service, even though Congress, in enacting ERISA, opted for a ten-year vesting requirement. *See* ERISA § 203(a). Such a broad reading of the savings clause thus would "permit the State, through its insurance laws, to reach far into areas governed by ERISA, and thereby negate the unmistakable intent of Congress to work a broad preemption," as the Massachusetts court conceded. J.S. at 21a.

The court below therefore eschewed such a reading of the savings clause, concluding, instead, that to be saved by that clause a state law must not only satisfy certain formal requirements (*i.e.* be addressed, in terms, to insurers) but also must "not conflict with the policies or operation of ERISA." J.S. at 5a; *see also id.* at 22a. That court determined that there is no conflict between the Massachusetts law at issue here and ERISA because the state law "affects *only* the substantive content of plans," a subject which, according to the state court, is "completely untouched by ERISA's regulatory provisions." *Id.* at 22a (emphasis added); *see also id.* at 5a n.4.

In reaching this conclusion the Massachusetts court rejected the proposition that by mandating insured-plan benefits the Massachusetts laws interfered with a congressional decision "to designate an area of private self-determination with respect to choice of benefits," as that court found no "persuasive evidence in the legislative history of an affirmative policy to curtail State police power in favor of private decision-making." *Id.* at 23a. And the court below likewise rejected the contention that state mandated-benefits conflict with a policy of allowing "interstate employers to maintain uniform plans," *id.*

at 5a-6a, concluding that to attribute such an intent to Congress would be "inconsistent . . . with the broad language of the insurance exemption," *id.* at 6a, which exemption, in that court's view, proved that Congress "could not have intended to mandate complete uniformity for the convenience of multi-state employers," *id.* at 24a.

As we proceed to show, the Massachusetts court has misunderstood Congress' intent. The legislative history of ERISA demonstrates that Congress emphatically protected private decision-making with respect to the content of benefit plans and that to the extent regulation was desirable, Congress concluded that uniform federal regulation was required to accommodate the needs of multi-state plans. Given that intent, the phrase "law . . . which regulates insurance" as used in the savings clause cannot be understood to mean a law which only in form is addressed to insurers. Rather, to satisfy this definition, a statute also must, *in substance*, concern the decisions of insurers, and not decisions of benefit-plan administrators or sponsors on such fundamental matters as what benefits to provide. In other words, a "law . . . which regulates insurance" is one as to which the burden of compliance falls directly on insurers rather than on benefit plans. A law mandating that particular benefits be provided by insured plans thus is not a "law . . . which regulates insurance" under the savings clause.[2]

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[2] In contrast, and by way of illustration, a law that required insurers to offer certain *options* in health insurance—for example, a mental health option—is a law regulating insurance (as are the more familiar forms of insurance regulation such as reserve requirements, reporting requirements for insurers, and the like). Such laws do not attempt to regulate the contents of benefit plans. A number of states have enacted laws mandating insurance options, at least with respect to treatment for alcoholism and drug dependency. *See* National Association of State Alcohol and Drug Abuse Directors, *Private Health Insurance Coverage for Alcoholism and Drug Dependency Treatment Services: State Legislation that Mandates Benefits or the Offering of Benefits for Purchase* at 5-6 (July, 1983).

Before turning to the legislative history we pause briefly to make two observations about the decision below —observations which highlight the implausibility of that decision.

First, it is important to note that the Massachusetts court failed to propose any definition of the critical statutory phrase "law . . . which regulates insurance" in the savings clause. Instead that court adopted what it termed a "conflict-based analysis" under which the determination of whether a particular law is within or outside the savings clause depends on a judicial decision, on a case-by-case basis, as to whether the law "conflict[s] with the policies or operation of ERISA." J.S. 5a. But nothing Congress said bespeaks an intent to set the courts at large to undertake such an *ad hoc* "conflict-based analysis."[3]

Second, under the decision below, states may mandate benefits for insured plans, but *not* for self-insured plans.[4] Consequently, insured plans will be put at a disadvantage as compared to self-insured plans; in Massachusetts, for example, an employer and union could agree to a health program that did not include mental health

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[3] It is also noteworthy that in *Shaw, supra,* the Court squarely rejected the proposition that ERISA preempts only state laws that are inconsistent with it. *See* 51 L.W. at 4971, 4973 & n.25. The Massachusetts court questioned that aspect of *Shaw*'s holding. *See* J.S. 6a.

[4] With respect to self-insured plans, the "deemer clause," ERISA § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B), precludes any possible attempt by a state to use its insurance law to circumvent § 514(a)'s preemptive force. The deemer clause provides in pertinent part:

> Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance for purposes of any law of any State purporting to regulate insurance companies, insurance contracts. . .

coverage only by creating a self-insured plan. And were other states to mandate other benefits that those states deem desirable, that "would make administration of a uniform nationwide plan more difficult," *Shaw v. Delta Air Lines, supra,* 51 L.W. at 4973 n.25, presenting multi-state plans with the "Hobson's choice" of "either abandon[ing] the funding of benefit plans through insurance policies or . . . accept[ing] all-encompassing uniform national contracts" that provide every benefit required by any state.[5]

It is most unlikely, to say the least, that a statute which was enacted for the very purpose of "assuring the equitable character . . . and . . . financial soundness" of benefit plans, ERISA § 2(a), 29 U.S.C. § 1001(a)—based upon Congress' finding that "the soundness and stability of plans . . . may be endangered," *id*—was meant to *discourage* the use of insurance as a method of funding benefit plans and to encourage self-insurance instead. *See also* pp. 24-25, *infra.* Yet that is the necessary consequence of the decision below. Not surprisingly, the legislative history demonstrates that Congress intended no such anomaly.

C. 1. The legislative history of ERISA begins in the Ninetieth Congress. During that Congress the Johnson administration submitted two bills (S. 1024 and S. 3421), which together would have established comprehensive federal regulation of employee benefit plans; those bills were introduced by Senator Yarborough as chairman of the Senate Committee on Labor and Public Welfare. During the same Congress, Senator Javits, the ranking minority

[5] Hutchinson & Ifshin, *Federal Preemption of State Law Under the Employment Retirement Income Security Act of 1974,* 46 U. Chi. L. Rev. 23, 68 (1978).

member of that committee, submitted his own bill (S. 1103) to regulate employee benefit plans.[6]

For present purposes what is most significant about the Yarborough and Javits bills is that both expressly disclaimed any preemptive effect. Section 18(a) of S. 1024, one of the Yarborough bills, provided:

> The provisions of this Act . . . shall not be held to except or relieve any person from compliance with any Federal or State law imposing affirmative obligations, duties, responsibilities or other standards of conduct with respect to the operation or administration of employee welfare or pension benefit plans.[7]

And § 508 of the Javits bill provided:

> Nothing in this Act shall be deemed to nullify any provision of any State or Federal law not in direct conflict with a provision of this Act.

The Senate committee held hearings in 1968 on the various pension bills that had been introduced, *see* Senate Committee on Labor and Public Welfare, Subcommittee on Labor, *Hearings on Pension and Welfare Plans,* 90th Cong., 2d Sess. (1968), but no legislation was reported by the committee.

[6] As Senator Javits observed, both "the administration bill as well as my own are heavily based upon the Cabinet Committee's report on private pension plans." Senate Committee on Labor and Public Welfare, Subcommittee on Labor, *Hearings on Pension and Welfare Plans,* 90th Cong. 2d Sess. 165 (1968). The Cabinet Committee, which had been appointed by President Kennedy in 1962, submitted a report in 1965 calling for remedial legislation in a number of areas. *See* S.Rep. 93-127, 93rd Cong., 1st Sess. 7 (1973) (discussing report).

[7] S.1024, the bill of which the quoted section was a part, addressed only reporting, disclosure and fiduciary requirements; the Johnson administration proposed a separate bill, S.3421, to establish minimum vesting and funding requirements and to create federal pension insurance. That latter bill had no preemption provision at all.

Work on federal pension legislation continued in the Ninety-First Congress. The various bills from the prior session were all reintroduced. *See* S.2167 (Javits bill); S.4326, 4327 (Johnson administration bills). In addition, the new Secretary of Labor, George Shultz, prepared a new piece of legislation, S.3859, supported by the Nixon administration, which was introduced for the administration by Senator Javits, *see* 116 Cong. Rec. 7278. That bill was more limited in scope than the original Javits' bill in that the Nixon administration bill did not have any minimum vesting or funding provisions but rather established only reporting and disclosure requirements and fiduciary standards. But for present purposes, the Nixon administration bill is significant because, unlike its predecessors, that bill would have had the effect of preempting state law with respect to the subjects the bill regulated. Specifically, § 18 of that bill provided:

> It is hereby declared to be the express intent of Congress that . . . the provisions of this Act shall supersede any and all laws of the States and of political subdivisions thereto insofar as they may now or hereafter relate to the fiduciary, reporting and disclosure responsibilities of persons acting on behalf of employee benefit plans.

Furthermore, the Nixon administration bill contained a "savings clause" which was identical to the one eventually enacted in ERISA: "nothing herein shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities." S.3589, § 18, 91st Cong., 2d Sess.

In introducing the Nixon administration bill, Senator Javits placed into the Congressional Record an explanatory statement and section-by-section analysis which said in pertinent part:

> The Act provides for a uniform source of law for evaluating the fiduciary conduct of persons acting on behalf of employee benefit plans and a singular reporting and disclosure system in lieu of the burdensome multiple reports.
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> * * *
>
> Section 18 designates the Act as the exclusive form of regulation for employee benefit plans within the areas covered, but provides that State laws which otherwise regulate insurance, banking and securities shall remain operative. [116 Cong. Rec. 7286, 7288]

Thus, at its creation, the combined force of an express preemption provision and the savings clause was stated to be to provide "exclusive [federal] regulation for employee benefit plans within the areas covered" by federal law and to preserve state laws that "*otherwise* regulate insurance."

No hearings were held in the Senate during the Ninety-First Congress with respect to the various pension bills, but hearings were held by Representative Dent's General Subcommittee on Labor of the House Labor and Education Committee. *See* House Committee on Education and Labor, General Subcommittee on Labor, *Hearings on Private Welfare and Pension Plan Legislation*, 91st Cong., 1st and 2d Sess. (1970). At those hearings, Secretary of Labor Shultz testified in support of the Nixon administration bill (which had been introduced in the House, without any explanation, by Rep. Ayres, as H.R. 16462, *see* 116 Cong. Rec. 7453). In his testimony Secretary Shultz laid down certain principles for developing federal regulation of benefit plans—principles that continued to be followed over the years during which ERISA was formulated, and are of relevance in understanding the preemption provision of ERISA:

> A balance of concerns exist that must be weighed in judging the private pension system. I am concerned about the worker whose expectations of receiving a pension after long years of service are disappointed because of the absence of a suitable vesting provision; about the workers who lose their accrued

pension rights for lack of sufficient funds in a plan when it is prematurely terminated; about the adequacy of the level of benefits for our retired workers, and about the restrictions on individual choice of benefit level built into our present system.

* * *

I am also concerned lest the Government intrude itself unduly into free collective bargaining about pensions; and I am concerned that private pension plans not lose their flexibility and their adaptability to meet needs in widely different circumstances, and about impairing the competitive position of the employers who provide pension coverage for their employees as against those who do not.

* * *

The need for uniform standards to guarantee benefit security also must be balanced against the possible loss of some freedom and flexibility in plan design and operation, which are valuable characteristics of the private system. [*Hearings on Private Welfare and Pension Plan Legislation, supra,* at 473-74 (emphasis added)]

Secretary Shultz went on to discuss the Nixon administration bill, explaining the rationale for its preemption provision as follows:

> Administrators of plans covering employees in several or more States will not have the burden of complying with several sets of State laws, rules, and regulations. They will be able to formulate procedures and conduct themselves with reference to one uniform law.
>
> Participants and beneficiaries will be able to judge fiduciary conduct according to a uniform standard. [*Id.* at 481]

Although the Nixon administration bill (along with all other pension bills) died in committee in the Ninety-First Congress—and although eventually a law was enacted far broader than that proposal—the bill nonetheless marked a turning point insofar as the preemption issue was concerned. From that time forward, every major bill that was introduced into Congress contained a preemption provision at least as broad as the one proposed by the Nixon administration, and each contained that administration's savings clause. This is true both of the bills introduced in the Ninety-Second Congress,[8] and also of the bills introduced in the Ninety-Third Congress, the one that enacted ERISA.

In the Ninety-Third Congress two bills became the focal points for the legislative effort to regulate benefit plans: S.4, introduced by Senators Williams and Javits, *see* Senate Committee on Labor and Public Welfare, *Legislative History of ERISA* at 93-190 (*"Leg. Hist."*), and H.R. 2, introduced by Representative Dent, *see* 1 *id.* at 3-67.[9] Each contained a preemption provision that

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[8] For example, at the start of the Ninety-Second Congress, Senator Javits introduced a modified version of the comprehensive pension bill he had offered in the prior Congress; his new bill, however, included a provision which, subject to the savings clause, would have preempted all state laws with respect to "the subject matters regulated by this Act." S.2, § 507, 92nd Cong. 1st Sess. (In introducing the bill, Javits noted this as one of the "more important differences" from his prior bill. 117 Cong. Rec. 283.) Similarly, Rep. Dent—who in the prior legislative session had introduced the Johnson administration bills with their non-preemptive provision, *see* H.R. 1045, 1046, 91st Cong. 1st Sess. (1971)—introduced in the 92nd Congress a bill that was pre-emptive with respect to state regulation of reporting, disclosure and fiduciary requirements. H.R. 1269 § 115, 92nd Cong. 1st Sess. (1971).

The Dent bill was not reported out of committee; the Javits bill was superseded by S.3598, 92nd Cong., 2d Sess., a bill which Senators Williams and Javits jointly introduced as a substitute for S.4. The Williams-Javits bills was reported out of the Senate Labor Committee, *see* S. Rep. 92-1150, 92nd Cong., 2d Sess. (1972) but was not acted upon by the Senate.

[9] As introduced, S.4 was identical to S.3598 as the latter had been reported out of the Senate Labor Committee in the prior Congress. *See* n.8 *supra.*

In addition to the bills mentioned in text, the Senate Finance Committee and House Ways and Means Committee developed their

was identical to its immediate predecessor: in S.4 a provision (§ 609) preempting state laws pertaining to "the subject matters regulated by this Act," 1 *Leg. Hist.* at 186-87; and in H.R. 2 a provision (§ 114) preempting state regulation of reporting, disclosure, and fiduciary requirements, 1 *Leg. Hist.* at 50-51. Each bill also contained a savings clause identical to the one eventually enacted.

The Senate bill was reported from committee with its preemption provision intact, 1 *id.* at 582-85; in the House committee the preemption provision was broadened so as to apply to state regulation of vesting and funding as well as to state regulation of reporting, disclosure and fiduciary standards, and the bill was then reported to the House, 1 *id.* at 2345-57.[10]

The reports of the two committees reveal a common animating philosophy. Both reports declare the same general approach to federal regulation of employee benefit plans:

> The Bill . . . represents an effort to strike an appropriate balance between the interests of employers and labor organizations in maintaining flexibility in the design and operation of their pension programs, and the need of the workers for a level of protection which will adequately protect their rights and just expectations. . . . This legislation strikes an appropriate and equitable balance between . . . those who advocate complete and stringent control of private pensions and those who oppose any form of supervisory or regulatory control. [S. Rep. 93-127, 93rd Cong. 1st Sess. 13-14 (1973); H.R. Rep. 93-533, 93rd Cong. 1st Sess. 9 (1973)]

own bills to amend the tax laws as they pertained to benefit plans. *See* 1 *Leg. Hist.* at 230-73 (S.1179 as introduced by Sen. Bentsen); 1 *id.* 780-1063 (S.1179 as reported); 2 *id.* 2393-2584 (H.R. 12481 as submitted and reported). The tax bills did not present any preemption issues. Eventually the tax bills and regulatory bills were incorporated into a single piece of legislation. *See also* n.12 *infra.*

[10] In the House bill, as reported, the savings clause applied only to state regulation of reporting, disclosure and fiduciary standards; there was no savings clause with respect to the provision of the bill preempting state regulation of vesting and funding. *See* 2 *Leg. Hist.* at 2345-47.

And each endorses the same approach towards preemption:

> Because of the interstate character of employee benefit plans, the Committee believes it essential to provide for a uniform source of law in the areas of vesting, funding, insurance and portability standards, for evaluating fiduciary and disclosure system in lieu of burdensome multiple reports. As indicated previously . . . the Act . . . provides that state laws regulating banking, insurance or securities remain unimpaired. [S. Rep. 93-127, *supra*, at 35; H.R. Rep. 93-533, *supra*, at 17.][11]

The Senate report is significant for one additional reason. Both the Senate and House bills, as reported, contained a provision—eventually enacted as ERISA § 506, 29 U.S.C. § 1136—authorizing the Secretary of Labor to make "agreements for cooperation or mutual assistance" with, or to "utilize . . . the facilities or services of any department, agency, or establishment of . . . any State or political subdivision of a State . . ." The House report did not comment on this provision but the Senate report did, stating:

> The states of Wisconsin and New York, for example, exercise supervision over certain pension and welfare funds in their respective jurisdictions, and the experience and technical know-how of these state agencies would be of valuable assistance to the Secretary. *It is not intended, however, that the state agencies*

[11] *See also* S. Rep. 93-127, *supra*, at 29 (stating need for uniformity with respect to fiduciary standards because "the operations of employee benefit plans are increasingly interstate"); H.R. Rep. 93-533, *supra*, at 12 (same).

> *utilized would formulate or apply substantive standards to plans subject to this Act which differ from the substantive standards in this Act.* [S. Rep. 93-127, *supra*, at 17-18 (emphasis added)]

The Senate and House passed their respective bills without altering the preemption provisions reported by the responsible committees. *See* 2 *Leg. Hist.* 2103-05; 3 *id.* 4457-59.[12] In conference, however, the preemption provision was broadened still further, as this Court has had occasion to note, *Shaw* v. *Delta Air Lines*, *supra*, 51 L.W. at 4971 & n.18: rather than preempting only "state laws relating to the specific subjects covered by ERISA" and thereby precluding only those laws that actually conflict with ERISA, § 514(a) was amended so as to preempt state law that "relate to any employee benefit plan," *i.e.*, *all* state laws on this subject.

Significantly, the legislative history indicates—and contemporaneous observers confirm[13]—that the preemption provision was broadened in conference in order to protect the autonomy of benefit plans, and in particular, to guard against threatened state regulation of the substance of prepaid legal service plans. Representative Dent alluded to this concern in his remarks to the House concerning the conference preemption provision, *see* 120 Cong. Rec. 29197 (preemption provision would apply to "any rule, regulation, practice or decision of any . . . professional society or association operating under code of law"), and Senator Williams stated the point explicitly in his post-conference statement to the Senate:

> Consistent with this principle, State professional associations acting under the guise of State-enforced professional regulation, should not be able to prevent unions and employers from maintaining the types of employee benefit programs which Congress has authorized—for example, prepaid legal services programs—whether closed or open panel . . . [*Id.* at 29933]

Furthermore, during the Senate debate on the conference bill, Senator Taft engaged Senators Williams and Javits in a colloquy concerning legal service plans during which Senator Javits stated that "the State, *directly or indirectly* through the bar, is preempted from regulating the form and content of a legal service plan," 3 *Leg. Hist.* at 4789, and Senator Williams added:

> This is an area that will not give to bar associations the authority to undo what we, in Congress, have permitted to be done, that is, *giving employers and unions the freedom to develop and operate legal service plans of their choice.* [3 *Id.* at 47900]

The debate on the conference bill is significant for a further reason: it reveals that Congress intended the ERISA preemption rule to be sweeping and the exceptions narrow. For example, Representative Dent stated:

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[12] The Senate bill was passed, as a non-germane amendment to H.R. 4200, a minor tax bill which had been approved by the House; this was done because the bill approved by the Senate made "major changes in our tax laws" and if the Senate were "to proceed to pass S.4 under that number the House would refuse to consider the bill on the constitutional grounds that revenue bills must originate in the House of Representatives." 2 *Leg. Hist.* at 1879.

In the House, after H.R. 2 was reported, the Labor Committee worked with the Ways and Means Committee to develop, as H.R. 12906, a revised version of H.R. 2 and, as H.R. 12855, a tax-code analogue for the regulatory provisions. *See* H.R. Rep. 93-807, 93rd Cong. 2d Sess. 1 (1974) (Ways and Means Report). Those two bills were adopted as amendments to H.R. 2, and, with those amendments, H.R. 2 was approved by the House. The Senate then adopted its bill as an amendment to H.R. 2. 2 *Leg. Hist.* 3597-99.

[13] *See* Turza & Halloway, *Preemption of State Law Under the Employee Retirement Income Security Act of 1974*, 28 Cath. U. L. Rev. 163, 167 (1979) (preemption provision broadened "[i]n response to organized labor's concern over state regulation of prepaid legal service plans and both business' and organized labor's concern about the increasing state regulation of interstate plans"). The principal author of this article was a legislative aide to Senator Javits when ERISA was enacted.

> I wish to make note of what is to many the crowning achievement of this legislation, the reservation to Federal authority of the sole power to regulate the field of employee benefit plans. With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent state regulation. . . .
>
> The conferees, *with the narrow exceptions specifically enumerated, applied this principle in its broadest sense to foreclose any non-Federal regulation of employee benefit plans.* [120 Cong. Rec. 29197]

Similarly, Senator Williams stated:

> It should be stressed that *with the narrow exceptions specified in the bill*, the substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans. *This principle is intended to apply in its broadest sense* to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of law. [*Id.* at 29933]

And Senator Javits added:

> Although the desirability of further regulation—at either the State or Federal level—undoubtedly warrants further attention, on balance, the emergence of a comprehensive and pervasive Federal interest and the interests of uniformity with respect to interstate plans required—but for certain exceptions—the displacement of State action in the field of private employee benefit programs. . . . If it is determined that the preemption policy devised has the effect of precluding essential legislation at either the State or Federal level, appropriate modification can be made. [*Id.* at 29942]

A fair summary of the congressional understanding of § 514 was provided in a report issued by the House Subcommittee on Labor Standards, chaired by Rep. Dent,

pursuant to a mandate contained in ERISA § 3022(a), during the congressional session immediately after ERISA was enacted.[14] That report states:

> ERISA, among its many provisions, provides for a significant adjustment in the regulatory roles of state and federal authority with respect to the various elements of the employee benefit plan field. The provisions of section 514 expressly reserve to Federal authority the regulation of employee benefit plans subject to the jurisdiction of the Act. In electing deliberately to preclude state authority over these plans, Congress acted to insure uniformity of regulation with respect to their activities. There was a recognition of the necessity for the preservation of some state activity in this field and *certain limited exceptions were made to the broad preemption scheme. In general these exemptions are designed to save state law as it is applid to entities which are not employee benefit plans* as defined in section 4(a) and not exempt under section 4(b), *to the extent that such regulation does not relate to employee benefit plans.*
>
> From the early 1970's the legislative activities which eventually produced ERISA involved various framings of preemption schemes. The Committee's hearing record prior to 1974 contains numerous discussions of the propriety of one approach or another.

---

[14] ERISA § 3022(a) required a "full study and review," during the Congress following enactment of the law, of several subjects including "(4) the effects and desirability of the Federal preemption of State and local law with respect to matters relating to pension and similar plans." The study was to have been conducted by the "Joint Pension Task Force" which was to be composed of the staffs of the various committees that had been responsible for the enactment of ERISA. *See* ERISA §§ 3021, 3022. The Joint Task Force was never constituted, however, and Rep. Dent's committee, acting pursuant to Rule X of the Rules of the House of Representatives for the Ninety-Fourth Congress, created its own Task Force on Welfare and Pension Plans. That Task Force conducted lengthy oversight hearings (some in conjunction with the House Ways and Means Committee) and issued the report quoted in text. *See* H.R. Rep. 94-1785, 94th Cong., 2d Sess. 38 (1977).

Once it had become clear that our policy would be the creation of uniform national standards, the problem was to extract these plans from the regulatory schemes in the several states without creating untoward side effects.

A number of states had undertaken to regulate employee benefit plans as such; others had already made, or appeared ready to declare, these plans subject to state control as insurers, trust companies, or investment companies. From a drafting standpoint the difficulty arose in attempting to extricate these plans from the framework of state insurance, trust and securities regulation even though their activities might very well bring them within the sphere of conduct historically subject to such regulation. On the one hand it was clear that the plans subject to ERISA needed to be freed of the possibility of state regulation; on the other hand, it was important to limit the effects of preemption, *in order to avoid disrupting state efforts to regulate the conduct of other financial entities not subject to the federal Act.*

* * *

Based on our examination of the effects of section 514, it is our judgment that the legislative scheme of ERISA is sufficiently broad to leave no room for effective state regulation within the field preempted. Similarly it is our belief that the Federal interest and the need for national uniformity are so great that enforcement of state regulation should be precluded.

* * *

We remain convinced of the propriety and necessity for the very broad preemption policy contained in section 514. To the extent that the scheme of regulation is found to be deficient with respect to some or all of the plans covered by the Act, we are prepared to consider amendments expanding or modifying the federal standards. We will be most reluctant to consider any remedy involving a limitation on the preemptive scheme as it applies to the plans

described in section 3(3) of Title I. [H.R. Rep. 94-1785, 94th Cong. 2d Sess. 46-47, 48 (1977)]

2. The legislative history just reviewed is instructive in four regards.

First, that history shows that contrary to the Massachusetts court's conclusion, *see* p. 7 *supra*, Congress clearly was intent on protecting "private decision-making" in the structuring of employee benefit plans. The Senate and House committee reports on the bills that became ERISA both state, as a formative principle underlying the Act, an intent to accommodate "the interests of employers and labor organizations in maintaining flexibility in the design and operation of their pension programs." P. 16 *supra*; *see also* p. 14 *supra* (Secretary Schultz's testimony). Moreover, a principal reason the scope of § 514(a) was broadened by the conference committee was precisely to preclude state regulation of "the form and content of a legal service plan," p. 19 *supra* (Sen. Javits), and thus to assure "employers and unions the freedom to develop and operate legal service plans of their choice," p. 19 *supra* (Sen. Williams).

Second, the legislative history likewise belies the Massachusetts court's attempt to minimize Congress' desire to allow "interstate employers to maintain uniform plans." *See* p. 7 *supra*. Beginning with the very first preemption proposal in 1970, the advocates of preemption consistently stated this as their principal rationale, *e.g.*, p. 15 *supra* (Secretary Schultz); the 1973 Senate and House committee reports therefore state that, "[b]ecause of the interstate character of employee benefit plans, the Committee believes it is essential to provide a uniform source of law . . ." p. 17, *supra*; and the 1977 House report reemphasizes that "the Federal interest and the need for uniformity are so great that enforcement of state regulation should be precluded," p. 22 *supra*.

Third, the legislative history—especially the explanatory statements following the conference report—estab-

lish that "Congress applied the principle of pre-emption 'in its broadest sense to foreclose any non-Federal regulation of employee benefit plans,' " and not just non-Federal regulation that conflicts with ERISA's rules. *Shaw v. Delta Air Lines*, *supra*, 51 L.W. at 4972. Those statements show with equal clarity that Congress viewed the savings clause as "creating only very limited exceptions to pre-emption." *Id.* *See also* p. 20 *supra* (Rep. Dent, Sen. Williams).

Fourth and finally, the legislative history contains not one iota of evidence to suggest that Congress intended to create a regime which would discourage or effectively preclude the use of insurance to fund employee benefits. To the contrary, the legislative history shows that the "most important purpose" of the Act is "to assure American workers that they may look forward with anticipation to a retirement with financial security and dignity," and that to do so the Act specifically seeks to assure "adequate funding" of pensions lest "a promise of pension" prove "illusory and empty." S. Rep. 93-127, *supra*, at 11, 10; H.R. Rep. 93-533, *supra*, at 8, 7. Congress recognized that one means of funding employee benefits is through the "purchase of insurance," ERISA § 3(1), 29 U.S.C. § 6 1002(1) (defining "employee welfare benefit plan"), and insured plans were viewed as safer than self-insured plans; the resulting preference for insurance is manifest in the very structure of the Act.[15] Thus, by attributing to Congress an intent to discourage the creation or maintenance of insured plans, the decision below flies in the face of Congress' intent.

[15] For example, ERISA § 302, 29 U.S.C. § 1082, establishes a complex set of minimum funding standards for pension plans, but under § 301(a)(2), 29 U.S.C. § 1081(a)(2), this set of standards is generally inapplicable to plans funded exclusively by insurance. Congress created this exemption because of the fact that insured plans "have behind them the funding of the insurance companies," H.R. Rep. 93-779, 93rd Cong. 2d Sess. 24 (1974) (House Ways and Means Committee); 2 *Leg. Hist.* 3316 (House Committee on Education and Labor explanatory material), and thus Congress concluded that such plans "will be properly funded," 2 *id.* 3342. For other examples of favored treatment of insured plans, *see, e.g.*, ERISA § 103(a)(C), 29 U.S.C. § 1023(a)(C), 29 U.S.C. § 1023(a)(C) (exempting insured plans from certain auditing requirements); § 406(b)(1), 29 U.S.C. § 1103(a) (insurance contracts, unlike all other assets of a benefit plan, need not be held in trust).

It is noteworthy in this regard that ERISA distinguishes between true insurance and plans in which an insurance company maintains a "separate account" for the premiums paid by the employer which account provides the sole source of money to fund benefits for the employer's employees. *See* ERISA § 3(17), 29 U.S.C. § 1002(17). Generally speaking, separate account plans—which are, in substance, a species of self-insurance—do not qualify for the favored treatment afforded to insured plans.

3. Given all this, there can be no doubt that, as the Massachusetts court itself recognized, *see* pp. 6-7 *supra*, the phrase "a law . . . which regulates insurance" cannot, in the context of the savings clause, refer to all laws which, in form, are addressed to insurers. As previously noted, such an interpretation would leave the states free to impose rules on insured benefit plans even with respect to those matters that Congress itself regulated, such as vesting requirements. *See* p. 7 *supra*. The legislative history establishes that, as early as 1970, the decision was made to establish uniform federal rules at least with respect to those subjects being regulated by ERISA; as the 1973 Senate committee report stated: "[i]t is not intended . . . that the state agencies . . . would formulate or apply substantive standards to plans subject to this Act which differ from the standards in this Act." Pp. 17-18 *supra*. Thus, the phrase "law . . . which regulates insurance"—which phrase appeared in every major pre-ERISA bill from 1970 forward—must refer to a class smaller than that consisting of all laws addressed to insurers.

Equally clearly—and contrary to the decision below—the savings clause cannot be read to permit all indirect state regulation of insured benefit plans that does not con-

flict with an express provision of ERISA. That interpretation is inconsistent with the congressional policies favoring private autonomy in establishing benefit plans, naitonal uniformity in regulating such plans, and the preference for insurance to fund such plans. Congress cannot be understood, in enacting what it saw as a "very limited" exception to the "broad[]" preemption rule of § 514(a), p. 24 *supra*, to have effectively nullified those critical policies with respect to insured plans by authorizing state regulation of the fundamental elements of such plans so long as the state law is in the form of insurance regulation.[16]

The conclusion is thus inescapable that a "law . . . which regulates insurance" within the meaning of the savings clause is a law that both in form *and in substance* is addressed to the decisions or actions of insurers. That is the meaning stated in the section-by-section analysis of the Nixon administration bill in which a preemption provision and the saving clauses were first developed and cojoined:

> Section 18 designates the Act as the exclusive form of regulation for employee benefit plans within the areas covered, but provides that State laws which otherwise regulate insurance . . . remain operative. [P. 13 *supra*]

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[16] In this regard, *Alessi* v. *Raybestos-Manhattan, Inc.*, *supra*, is instructive. At issue in that case was a state workers compensation statute under which workers compensation benefits could not be used to offset pension benefits. In holding that law preempted by § 514(a) the Court stated:

> It is of no moment that New Jersey intrudes indirectly, through a workers compensation law, rather than directly, through a statute called "pension regulation." ERISA makes clear that even indirect state action bearing on private pension plans may encroach upon the area of exclusive federal concern. . . . *ERISA's authors clearly meant to preclude the States from avoiding through form the substance of the preemption provision.* [451 U.S. at 525; emphasis added]

That is likewise the meaning stated by the House report issued in the Congress after ERISA was enacted which says that the purpose of the "limited exceptions" was "to avoid disrupting state efforts to regulate the conduct of other financial entities not subject to the federal Act." P. 22 *supra*. And that is the only interpretation, we submit, that makes sense of the statutory language and that accords with Congress' intent. Accordingly, because the Massachusetts law at issue here concerns the types of benefits to be provided by benefit plans —a fundamental decision for private parties to make in creating such plans—the statute is not a "law . . . which regulates insurance" within the meaning of the savings clause and hence is preempted by ERISA § 514(a).

CONCLUSION

For the foregoing reasons, the judgment of the Massachusetts Supreme Court Judicial should be reversed.

Respectfully submitted,

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Nos. 84-325 and 84-356

IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

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Appellant

v.

COMMONWEALTH OF MASSACHUSETTS

THE TRAVELERS INSURANCE COMPANY,
Appellant

v.

COMMONWEALTH OF MASSACHUSETTS

ON APPEALS FROM THE SUPREME JUDICIAL COURT FOR THE COMMONWEALTH OF MASSACHUSETTS

BRIEF AMICUS CURIAE OF HEALTH INSURANCE ASSOCIATION OF AMERICA IN SUPPORT OF THE APPELLANTS

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BRIEF AMICUS CURIAE OF HEALTH INSURANCE ASSOCIATION OF AMERICA IN SUPPORT OF THE APPELLANTS

INTEREST OF AMICUS CURIAE

Health Insurance Association of America ("HIAA"), a Delaware nonprofit corporation, is an association of 327 private insurance companies, including the Appellants, Metropolitan Life Insurance Company and The Travelers Insurance Company.[1] HIAA's member companies write over 85% of the health insurance policies written by private insurance

[1] HIAA's member companies do not include nonprofit plans such as Blue Cross and Blue Shield.

companies in the United States. At year-end 1982, approximately 112 million Americans were covered by health policies from private insurers.[2] Approximately 85% of these people are covered under group health insurance policies, a substantial majority of which provide health insurance coverage to employee benefit plans that are regulated by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§1001 *et seq.*

The issue in these appeals—whether employee benefit plans regulated by ERISA ("ERISA plans") are subject to state mandated health benefit laws—is one of substantial concern to HIAA and its member companies.

A mandated health benefit law is one that requires a health insurance policyholder to purchase coverage for a particular health care service. Section 47B of Massachusetts General Laws Chapter 175 ("Section 47B") is such a law in that it requires all health insurance policies to include, for Massachusetts residents, certain minimum benefits for expenses arising from the treatment of mental or nervous conditions. With respect to these benefits, the policyholder has no choice. If he wishes to purchase any health insurance at all, he must purchase the coverage mandated by state law.

Mandated health benefit laws dictate what benefits must be included in health insurance policies. When the benefits provided by an ERISA plan are insured by a group health insurance policy, mandated health benefit laws, such as Section 47B, also dictate what benefits must be provided by the plan.

HIAA and its member companies have consistently opposed the enactment of state mandated health benefit laws because of their impact on ERISA plans: these laws restrict design flexibility, inhibit uniformity in benefit packages, increase costs to employers and employees, and create strong disincentives to securing employee benefits through the purchase of insurance.

[2] Health Insurance Association of America, *Source Book of Health Insurance Data, 1982–1983*, Table 1.2 (1984 Update).

Because the Court's decision will determine the enforceability against insured ERISA plans, not only of Section 47B, but of state mandated health benefit laws throughout the country, these appeals are of substantial interest and importance to HIAA and its member companies.

HIAA and its member companies submit that the Supreme Judicial Court for the Commonwealth of Massachusetts was wrong in holding that Section 47B is not preempted by ERISA. Accordingly, HIAA, as the national trade association of the private health insurance industry, files this Brief Amicus Curiae in support of the Appellants. Consent to the filing of this Brief has been obtained from counsel for the Appellants and the Appellee.

SUMMARY OF ARGUMENT

This Court addresses for the first time the question of whether ERISA preempts a state mandated health benefit law. These appeals pose this question in the context of the enforceability of Section 47B against insured ERISA plans.

By dictating benefits that must be provided by an insured ERISA plan, Section 47B indisputably relates to the plan and, therefore, comes within the broad preemption of Section 514(a) of ERISA, 29 U.S.C. §1144(a) (the "ERISA preemption"). Contrary to the decision of the Supreme Judicial Court, Section 47B is not saved from preemption by Section 514(b)(2)(A) of ERISA, 29 U.S.C. §1144(b)(2)(A) (the "savings clause").

It is evident from the legislative purposes of ERISA, as reflected in its legislative history and elaborated upon in the decisions of this Court in *Alessi v. Raybestos—Manhattan, Inc.*, 451 U.S. 504 (1981) and *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 103 S.Ct. 2890 (1983), that a mandated health benefit law, such as Section 47B, is not a law which regulates insurance within the meaning of the savings clause.

In enacting the savings clause, Congress intended to preserve only those state laws that protect insurance policy-

holders, including ERISA plans, against practices or activities of insurance companies.[3] Such laws regulate marketing and advertising practices, underwriting and rate setting practices, claims payment practices, reserves and investments and other activities which affect the dealings of the insurance company with the policyholder and the reliability of the coverage purchased.

A state mandated health benefit law is not enacted to protect the policyholder from insurance company practices or activities. Rather, it uses insurance as a means of financing, and therefore promoting, particular health care services, to the detriment of the insurance policyholders whose market choices it restricts.

ARGUMENT

HIAA asks the Court to reverse the decision of the Supreme Judicial Court for the Commonwealth of Massachusetts and to hold that Section 47B is not enforceable against insured ERISA plans.

I.

SOUND PUBLIC POLICY DICTATES THAT INSURED ERISA PLANS SHOULD NOT BE SUBJECT TO STATE MANDATED HEALTH BENEFIT LAWS.

Twenty-six states have enacted a total of nearly 70 mandated health benefit laws covering a wide range of health care services.[4] Half of these have enacted laws, similar to Section 47B, requiring health insurance coverage for the

[3] Throughout this Brief, the term "policyholder" includes those being solicited to become policyholders.

[4] In the Appendices to its Brief Amicus Curiae in Support of Jurisdictional Statements, HIAA provided a generalized state-by-state summary of mandated health benefit laws as well as other state laws that attempt to affect the health benefits provided by group policies, including those issued to ERISA plans.

treatment of mental and nervous disorders. One reason for the widespread appearance of such laws has been the dedicated lobbying of mental health care providers, most notably psychiatrists, psychologists, psychotherapists and social workers.

State mandated health benefit laws shift the payment obligation for particular health care services away from the consumer of those services to, in this instance, the ERISA plan.[5] This shift promotes the utilization of the health care services for which benefits are mandated and virtually guarantees that the provider of the services will be paid a reasonable fee for services rendered. It is little wonder that in state after state health care providers have been the principal, and in many instances the only, advocates of mandated health benefit laws.

In the context of ERISA plans, state mandated health benefit laws impose benefits and costs which neither the employer nor the employees may reject or avoid in determining the benefit mix of the plan. As a consequence, these laws severely restrict the freedom of ERISA plans to provide health benefits at a reasonable cost to meet employee needs.

The detrimental effects of mandated health benefit laws on ERISA plans are of three basic types:[6]

State mandated health benefit laws restrict the ability of ERISA plans to tailor health benefit packages to meet the needs of plan beneficiaries and inhibit multistate plans from developing uniform health benefit packages on a national ba-

[5] Although the payment obligation is nominally shifted to an insurance company which either pays the health care provider or reimburses the health care consumer, it is the group policyholder—in this instance the ERISA plan—that actually bears the payment obligation. Premiums for most group coverage are based on prior claims experience. Therefore, what is paid by the insurance company in claims is ultimately paid by the policyholder in future premium payments.

[6] *See generally* Younger, *Mandated Insurance Coverage—The Achilles Heel of State Regulation?*, XXIV A. of Life Ins. Counsel Proc. 765-82 (1978); Buchman, *Extraterritorial Application of State Mandated Group Health Benefits*, 15 Forum 880 (1980).

sis. A cost-effective package of health benefits requires both *flexibility* and *uniformity*—that is, flexibility to design a program that provides the benefits selected by the plan and uniformity that permits each employee, regardless of the state in which he works or lives, to receive the same benefits and to bear the same costs for these benefits as other members of the plan.

State mandated health benefit laws frustrate these design requirements. They force employers and unions to purchase coverages that they neither want nor need. Not only does this unnecessarily increase the cost of insurance for ERISA plans, it also reduces the number of dollars available to these plans for other, more desired benefits.

Moreover, if a mandated health benefit law is enacted to apply to all residents of a state regardless of whether the group policy itself was issued or delivered in the state, uniformity of benefits is impossible.[7] The benefits provided by the group policy must conform not only to the statutory requirements of the state in which the policy was issued and delivered but also to the requirements of the mandated health benefit laws applicable to insureds living in other states. For ERISA plans, this not only introduces administrative complexity, which increases the cost of providing health insurance to the plan, but also results in inequities among plan members inasmuch as some members receive greater benefits than others simply by reason of the state in which they live or work.[8]

[7] Such laws are generically referred to as "extraterritorial". Because group insurance policies are traditionally governed by the laws of the jurisdiction in which they are issued and delivered rather than the laws of the jurisdiction in which each insured lives or works, *Boseman v. Connecticut General Life Insurance Co.*, 301 U.S. 196 (1937), state insurance laws are said to have extraterritorial application when they are intended to affect policies issued and delivered in other jurisdictions. Because Section 47B applies to all group policies, to the extent that they insure Massachusetts residents, regardless of the state of issuance and delivery, Section 47B is extraterritorial.

[8] The problems created by extraterritorial mandated health benefit laws are akin to those recognized by the Court in *Shaw v. Delta Air Lines, Inc.*, 103 S. Ct. at 2904 n.25, regarding the impact of state fair employment laws on multistate ERISA plans.

State mandated health benefit laws are a major contributor to the rapidly escalating cost of health insurance for ERISA plans. Conservative estimates by industry experts place the cost of mandated health benefits at approximately 10% of the policy premium. Other industry experts believe that a more realistic estimate would place the cost of mandated health benefits closer to 20% of the policy premium.

Mandated health benefit laws contribute to increased costs to ERISA plans for several reasons. First, the policy becomes more complicated and, therefore, more costly to administer. These administrative costs are "dead dollars" in that they do not result in increased policy benefits. Second, the policy becomes more expensive because it carries unwanted coverages that the plan was forced by law to purchase. Third, the policy becomes more expensive because the underlying health care costs increase. State mandated health benefit laws are intended to encourage the use of services for which coverage is mandated. Increased use translates directly into increased claims, which in turn results in larger future premiums for group policyholders.

State mandated health benefit laws create disincentives to purchasing insurance. Coverages that are required by state law but unwanted by the policyholder increase the likelihood that the policyholder will choose to buy *no* health insurance at all rather than bear the cost of unwanted coverages. During the last decade, as more states have enacted more mandated health benefit laws at the behest of health care providers, employers and unions have done precisely this. Rather than insuring ERISA plans, an increasing number of employers and unions have elected to fund the benefits themselves. Because ERISA prohibits states from regulating *uninsured* ERISA plans, self-funding effectively enables the plan to avoid state regulation of plan benefits.[9]

[9] Section 514(b)(2)(B) of ERISA, 29 U.S.C. §1144(b)(2)(B), (the "deemer clause") prohibits states from regulating ERISA plans by deeming them to be insurance companies. Courts have consistently interpreted and applied the deemer clause to prohibit state regulation of uninsured plans. *General Split Corp. v. Mitchell*, 523 F. Supp. 427 (E.D. Wisc. 1981); *St. Paul Electrical Workers Welfare Fund v. Markman*, 490 F. Supp. 931 (D. Minn. 1980); *Hewlett-Packard Co. v. Barnes*, 425 F. Supp. 1294 (N.D. Cal. 1977); *aff'd per curiam*, 571 F.2d 502 (9th Cir. 1978).

When an employer or union chooses *not* to purchase health insurance for an ERISA plan, employees and union members suffer because uninsured health benefits are inherently less secure than insured benefits. State insurance laws and regulations protect against insurance company insolvency. No similar protections are available to assure that the assets of an uninsured plan will be sufficient to pay benefits to plan members.

Indeed, one of the major ironies of this case is that if state mandated health benefit laws were to be held to be preserved by the savings clause with respect to *insured* plans, employers and unions would be further encouraged to reject insurance and to provide *uninsured* plans to employees and union members. Because the benefits of an uninsured plan are plainly less secure than those of an insured plan, this result conflicts with the stated purpose of ERISA "to protect . . . the interests of participants in employee benefits plans and their beneficiaries. . . ." Section 2(b) of ERISA, 29 U.S.C. §1001(b).[10]

HIAA submits that, as a matter of sound public policy, employers and unions should not be forced to choose between submitting to costly and restrictive state mandated health benefit laws or leaving the health benefits of their ERISA plans uninsured. HIAA further submits that this sound public policy is reflected in the ERISA preemption and that, as a matter of federal law, ERISA plans are not subject to state laws that dictate health benefits, irrespective of whether these plans are insured or uninsured.

II.

CONGRESS INTENDED ERISA TO PREEMPT STATE LAWS WHICH DICTATE THAT PLANS PROVIDE CERTAIN HEALTH BENEFITS.

The decision in these appeals turns on legislative intent. Both the legislative history of ERISA and this Court's previous decisions construing the scope of the ERISA preemption dictate the conclusion that, in enacting ERISA, Congress intended to preempt state laws, like Section 47B, which would require ERISA plans to provide certain health benefits, irrespective of whether these benefits are insured or uninsured.

[10] For a recent discussion of problems associated with uninsured plans, see Buchman, *Insured and Uninsured METs-Current Problems*, 16 Conn. L. Rev. 453 (1984).

a.

ERISA was enacted to provide a comprehensive federal response to what were perceived to be widespread problems and abuses in the area of employee benefit plans. As this Court observed in *Nachman Corp. v. Pension Benefit Guaranty Corp.*, 446 U.S. 359, 361 (1980) and again in *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. at 510, ERISA is a "comprehensive and reticulated statute", which Congress adopted only after careful study of such plans.

In enacting ERISA, Congress considered the history of prior federal involvement and existing state law (S. Rep. No. 93-127, 93d Cong., 2d Sess. 2-7 (1973)), and concluded that the fragmentary federal and state law that applied to employee benefit plans had not been effective in protecting participants from deprivation of anticipated benefits or in promoting expansion of such plans. Section 2 of ERISA, 29 U.S.C. §1001; H.R. Rep. No. 93-533, 93d Cong., 2d Sess. 1-5 (1973); H.R. Rep. No. 93-807, 93d Cong., 2d Sess. 8-9 (1974); S. Rep. No. 93-127, 93d Cong., 2d Sess. 1-7 (1973). A comprehensive federal approach was required.

As a means of ensuring this comprehensive federal approach to employee benefit plan regulation, Congress enacted the ERISA preemption. The legislative history amply supports the conclusion that, in so doing, Congress intended to occupy the field of employee benefit plan regulation. The conference committee that reported the final version of the bill emphasized that:

> the provisions of title I are to supersede all State laws that relate to any employee benefit plan that is established by an employer engaged in or affecting interstate commerce or by an employee organization that

represents employees engaged in or affecting interstate commerce.

H.R. Rep. No. 93-1280, 93d Cong., 2d Sess. 383 (1974).

In floor debate concerning the conference report, Congressman Dent, the Chairman of the Subcommittee on Labor of the House Labor and Education Committee, elaborated on the purpose of the ERISA preemption by saying that

> [t]he conferees, with the *narrow exceptions* specifically enumerated, applied this principle *in its broadest sense* to foreclose any non-Federal regulation of employee benefit plans. This [preemption] would reach any rule, regulation, practice or decision of any State, subdivision thereof or any agency or instrumentality thereof . . . which would affect any employee benefit plan as described in section 4 (a) and not exempt under section 4 (b).

120 Cong. Rec. 29,197 (1974) (emphasis supplied).

Senator Williams, Chairman of the Senate Committee on Labor and Public Welfare, indicated the reason for the broad preemption:

> It should be stressed that with the *narrow exceptions* specified in the bill, the substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulation, *thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans.*

120 Cong. Rec. 29,933 (1974) (emphasis supplied).

Senator Javits, the senior Republican on the Senate Committee on Labor and Public Welfare, noted during the floor debates on ERISA that

> [a]lthough the desirability of further regulation—at either the State or Federal level—undoubtedly warrants further attention, on balance, the emergence of a comprehensive and pervasive Federal interest *and the interests of uniformity with respect to interstate plans* required—but for certain exceptions—the displacement of State action in the field. . . .

120 Cong. Rec. 29,942 (1974) (emphasis supplied). *See also* Turza & Halloway, *Preemption of State Law under the Employee Retirement Income Security Act of 1974*, 28 Cath. U.L. Rev. 163, 167 (1979); Hutchinson & Ifshin, *Federal Preemption of State Law under the Employee Retirement Income Security Act of 1974*, 46 U. Chi. L. Rev. 23, 38-43 (1978).

This legislative history dictates the conclusion that Congress intended the ERISA preemption to be broadly applied and the savings clause to be narrowly construed.

b.

On two occasions this Court has addressed the scope of the ERISA preemption and has held it to be applied broadly. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 103 S. Ct. 2890 (1983); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981). Both cases strongly support the proposition that a state law, like Section 47B, which would require ERISA plans to provide certain health benefits, is inconsistent with the broad legislative purposes of the ERISA preemption.

In *Alessi* the Court unanimously held that the New Jersey Workers' Compensation Act was preempted by ERISA insofar as the state law prohibited workers' compensation payments from being set off against pension benefits payable by an ERISA plan. While acknowledging that workers' compensation awards were "obviously . . . subject to the State's police power", 451 U.S. at 524, the Court concluded that even indirect intrusion upon the provisions of an ERISA plan could not escape the ERISA preemption.

> It is of no moment that New Jersey intrudes *indirectly*, through a workers' compensation law, rather than directly, through a statute called 'pension regulation'. ERISA makes clear that even *indirect* state action bearing on private pensions may encroach upon the area of exclusive federal concern.

451 U.S. at 525 (emphasis supplied).

The same, of course, may be said for state mandated health benefit laws: while these laws are within a state's police power, the state is prohibited by the ERISA preemption from dictating the benefits an ERISA plan, either directly, or, as in the case of Section 47B, indirectly through the plan's group health insurance policy.

The Court in *Alessi* also observed that Congress had reserved decisions on pension calculation techniques "to the discretion of pension plan designers". 451 U.S. at 525. Similarly, the selection of health benefits to be provided by an ERISA plan appropriately is left to the discretion of plan designers. Because state laws, like Section 47B, limit this discretion, they conflict with the legislative purposes of ERISA.[11]

This discretion and design flexibility are all the more important where the benefit package emerges from collective bargaining. As the Court stated in *Alessi*: "the additional federal interest in precluding state interference with labor-management negotiations calls for preemption of state efforts to regulate pension terms. . . . As a subject of collective bargaining, pension terms themselves become expressions of federal law, requiring preemption of intrusive state law." 451 U.S. at 525 (citations omitted). By analogy, to the extent the benefit mix in an ERISA plan is subject to collective bargaining, the state's attempt to interfere with this process by enacting mandated health benefit laws contravenes federal labor policy.[12]

[11] In *Alessi* specific legislative history supported the conclusion that pension calculation techniques were to be left to the discretion of pension plan designers. 451 U.S. at 514-16. The reasoning with respect to benefit selection is identical. Plan designers should be permitted to weigh costs and benefits and determine a benefit mix that is consistent with plan objectives.

[12] The Brief of the Appellant The Travelers Insurance Company, to which HIAA subscribes, addresses this aspect of these appeals in detail.

In *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 103 S. Ct. 2890 (1983), the Court unanimously held that the New York Human Rights Law was preempted by ERISA and that the New York Disability Benefits Law was preempted insofar as it applied to an ERISA plan not maintained solely for the purpose of complying with that state law.

The New York Human Rights Law, as construed by the New York Court of Appeals, prohibits an ERISA plan from treating pregnancy differently from other nonoccupational disabilities, and the New York Disability Benefits Law requires employers to pay certain benefits to employees unable to work because of nonoccupational injuries or illness, including pregnancy-related disabilities.

The Court in *Shaw* had no difficulty concluding that these state laws were within the broad reach of the ERISA preemption:

> The breadth of §514(a)'s pre-emptive reach is apparent from that section's language. A law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such plan. Employing this definition, the Human Rights Law, *which prohibits employers from structuring their employee benefit plans* in a manner that discriminates on the basis of pregnancy, and the Disability Benefits Law, *which requires employers to pay employees specific benefits*, clearly 'relate to' benefit plans.

103 S. Ct. at 2899-2900 (emphasis supplied; footnotes omitted).

The Court's decision that the state laws were preempted by ERISA was based in part on the conclusion that Congress intended to minimize the burden on *multistate* employers to administer plans differently in each state in which they have employees. 103 S. Ct. at 2904-5. The Court elaborated on this point with respect to the New York Human Rights Law:

> An employer with employees in many States might find that the most efficient way to provide benefits to

those employees is through a single employee benefit plan. *Obligating the employer to satisfy the varied and perhaps conflicting requirements of particular state fair employment laws, as well as the requirements of Title VII, would make administration of a uniform nationwide plan more difficult.* The employer might choose to offer a number of plans, each tailored to the laws of a particular State; the inefficiency of such a system presumably would be paid by lowering benefit levels. Alternatively, assuming that the state laws were not in conflict, the employer could comply with the laws of all States in a uniform plan. To offset the additional expenses, the employer presumably would reduce wages or eliminate those benefits not required by any State. Another means by which the employer could retain its uniform nationwide plan would be by eliminating classes of benefits that are subject to state requirements with which the employer is unwilling to comply. *ERISA's comprehensive pre-emption of state law was meant to minimize this sort of interference with the administration of employee benefit plans.*

103 S. Ct. at 2904 n. 25 (emphasis supplied). This description of the obvious impact of state law on multistate plans argues convincingly for the preemption not only of state fair employment laws, but of state laws, like Section 47B, which dictate that insured plans provide different health benefits to plan members residing or working in different states.

III.

A MANDATED HEALTH BENEFIT LAW DOES NOT PROTECT POLICYHOLDERS FROM INSURANCE COMPANY PRACTICES, AND, THEREFORE, IS NOT A LAW WHICH REGULATES INSURANCE WITHIN THE MEANING OF THE SAVINGS CLAUSE.

The legislative history of ERISA and this Court's decisions in *Alessi* and *Shaw* make a compelling case that Con-

gress intended ERISA to preempt state laws that interfere with the uniform administration of ERISA plans and with the flexibility and discretion of plan designers.

Indisputably, state mandated health benefit laws, like Section 47B, have this effect. The Supreme Judicial Court nevertheless held that, because Section 47B operates through a plan's group health insurance policy rather than on the plan directly, it is a law which regulates insurance and, therefore, is within the scope of the savings clause.

A number of appellate courts have addressed the relationship of a state mandated health benefit law and ERISA. *Attorney General v. The Travelers Insurance Co.*, 391 Mass. 730, 463 N.E.2d 548 (1984), *juris. noted* 105 S. Ct. 320 (1984); *Insurance Commissioner v. Metropolitan Life Insurance Co.*, 296 Md. 334, 463 A.2d 793 (1983); *Wadsworth v. Whaland*, 562 F.2d 70 (1st Cir. 1977), *cert. denied* 435 U.S. 980 (1978). None of these cases has engaged in a substantive analysis of whether a state mandated health benefit law is one that regulates insurance within the meaning of the savings clause.[13]

The question posed by these appeals is far more complex than a reading of the opinions cited above would lead one to believe. These courts have largely assumed that, because a mandated health benefit law is found in the state insurance

[13] Not coincidentally, the one appellate court that did engage in such an analysis concluded that the state mandated health benefit law in question did *not* regulate insurance within the meaning of the savings clause, and held the state law unenforceable against an insured ERISA plan. *Metropolitan Life Insurance Co. v. Insurance Commissioner*, 51 Md. App. 122, 441 A.2d 1098 (1982), *rev'd* 296 Md. 334, 463 A.2d 793 (1983). In reversing this decision the Maryland Court of Appeals ignored completely the reasoning of the intermediate court. See *Michigan United Food & Commercial Workers Unions v. Baerwaldt*, 572 F. Supp. 943, 950-52 (E.D. Mich. 1983), in which the court similarly concluded that state mandated health benefit laws are not laws which regulate insurance within the meaning of the savings clause.

code, it is a law which regulates insurance.[14] The issue posed by these appeals is not whether a state mandated health benefit law *affects* insurance policies but whether, when its substantive effect is examined, it is a law which *regulates* insurance within the meaning of the savings clause.

HIAA submits that Section 47B and other state mandated health benefit laws are not laws which regulate insurance within the meaning of the savings clause. Congress carved out this exception to the ERISA preemption in order to give ERISA plans the benefit of those state laws that have traditionally afforded insurance policyholders protection against insurance company activities or practices.[15] Because Section 47B and other state mandated health benefit laws are not laws that protect the policyholder from injury that might be suffered as a result of insurance company activities or practices but rather are laws that use insurance to finance and, hence, to promote particular health care services, they are not laws of the type Congress intended to be saved from preemption.

a.

The legislative history of ERISA does not reveal Congress' view on what constitutes a "law . . . which regulates insurance. . . ." Therefore, it is necessary to infer legislative

[14] In contrast to this approach, see *Stone & Webster Engineering Corp. v. Ilsley*, 518 F. Supp. 1297, 1299 n.2 (D. Conn. 1981), *aff'd* 690 F.2d 323 (2d Cir. 1982), *aff'd sub nom. Arcudi v. Stone & Webster Engineering Corp.*, 103 S. Ct. 3564 (1983) (a state law requiring employer contributions to an employee union welfare fund providing life and health insurance benefits is not a law regulating insurance but rather a law aimed at *employers* and, as such, is preempted by ERISA). See also *Securities & Exchange Commission v. National Securities*, 393 U.S. 453, 460 (1969), in which the Court observed that a particular state law "is not insurance regulation, but securities regulation. It is true that the state statute applies only to insurance companies. But mere matters of form need not detain us."

[15] As Chief Judge Feikens concluded in *Michigan United Food & Commercial Workers Unions v. Baerwaldt*, 572 F. Supp. at 951: "The saving clause may preserve the state's power to regulate certain types of institutions important to the fabric of state life, and generally excluded from federal regulation, but I would confine the term 'regulates insurance' so as to exclude laws which do not so much monitor the insurance industry as its customers from the clause's protection."

intent from the structure and purpose of the ERISA preemption, and from the common understanding of state insurance regulation.

ERISA'S declared purpose is "to protect . . . the interest of participants in employee benefit plans and their beneficiaries. . . ." Section 2(b) of ERISA, 29 U.S.C. §1001(b). ERISA itself provides certain important protections "by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect [to ERISA plans], by establishing standards of conduct, responsibility and obligation for fiduciaries of [ERISA] plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts." *Id.*

Logically, in enacting the ERISA preemption, Congress would not have wished to preempt certain classes of state laws that themselves might provide important protection to plan participants and beneficiaries. State laws regulating insurance, banking and securities practices were three such areas designated by Congress in the savings clause.

Although Congress, in enacting the savings clause, would logically have sought to gain for ERISA plans the protection of state insurance, banking and securities laws, Congress would not have wanted ERISA plans to bear the burden of these laws by being treated as insurance companies, banks or investment companies. Therefore, it enacted the deemer clause, which provides that an ERISA plan shall not, for purposes of applying state laws which regulate insurance, banking or securities, "be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking. . . ."

In the context of the types of state insurance laws contemplated by Congress in enacting these provisions, the distinction created by the savings clause, on the one hand, and the deemer clause, on the other hand, makes perfect sense. To the extent state insurance laws protect the policyholder, they are saved and may be used by ERISA plans for the

benefit of plan participants and beneficiaries where plans purchase insurance to underwrite benefits. The state, however, may not use these laws to impose obligations on, or restrict the activities of, an ERISA plan by deeming the plan to be an insurer. *Accord Michigan United Food & Commercial Workers Unions v. Baerwaldt,* 572 F Supp. at 952. *See also* Note, *Insurance Regulation—Employee Benefit Plans,* 28 Ark. L. Rev. 515 (1975).

While this structure is logical if the state law is one that regulates the activities or practices of the insurance company in its dealings with policyholders, the logic breaks down where, as here, the state law imposes an obligation on, or restricts the activities of, the policyholder. If such a law is construed to be a law which regulates insurance within the meaning of the savings clause, a strong incentive is created in the policyholder to terminate or avoid the insurance relationship in order to escape the unwanted obligations and restrictions. This is precisely what has happened with respect to state mandated health benefit laws. Because these laws dictate the insurance coverage that ERISA plans must purchase if they purchase any insurance at all, plans that wish to avoid the restrictions placed on their purchasing decisions are inclined to forego insurance and self-fund the health benefits which they elect to provide. Because ERISA plans that self-fund health benefits may not, under the deemer clause, be deemed insurance companies, state mandated health benefit laws are unenforceable against self-funded plans. *General Split Corp. v. Mitchell,* 523 F. Supp. 427 (E.D. Wisc. 1981); *St. Paul Electrical Workers Welfare Fund v. Markman,* 490 F. Supp. 931 (D. Minn. 1980); *Hewlett-Packard Co. v. Barnes,* 425 F. Supp. 1294 (N.D. Cal. 1977), *aff'd per curiam,* 571 F.2d. 502 (9th Cir. 1978).

Congress surely did not intend, in enacting the savings and deemer clauses, to create this arbitrary distinction between insured and uninsured plans, permitting state regulation of plan benefits if they are insured but not if they are uninsured. Yet this is the inescapable, albeit nonsensical, result if state mandated health benefit laws are construed to

be laws which regulate insurance within the meaning of the savings clause.

b.

The conclusion that Congress only intended to save from the ERISA preemption state insurance laws that protect the plan from the practices or activities of insurance companies is consistent with the traditional purposes of state insurance regulation. States, rather than the federal government, have historically protected the policyholder from the potentially injurious practices or activities of insurance companies. Indeed, Congress has recognized this as the exclusive domain of the states. It is logical that Congress, in enacting the ERISA preemption, would have wished to save for the benefit of plan participants and beneficiaries, those state laws which by tradition and common understanding have provided important protections to insurance policyholders. These include regulation of rates, rate-making, unfair and deceptive practices, commissions, investments, and other matters dealing with the cost and reliability of coverage and the fairness of company underwriting practices.[16]

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[16] The United States District Court for the District of Kansas, in holding that a program offered by a third-party payor was not an ERISA plan subject to the ERISA preemption but rather an insurance program subject to state regulation, observed that the purposes of insurance regulation are:

> first, to avoid overreaching by insurers; second, to assure solidity and solvency of insurers; third, to assure that rating classifications and rates are reasonable and fair.

Bell v. Employee Security Benefit Association, 437 F. Supp. 382, 391 (D. Kan. 1977), quoting with approval from Note, *Insurance Regulation—Employee Benefit Plans,* 28 Ark. L. Rev. at 517-18. All of these purposes relate to policyholder protection; none are served by mandated health benefit laws, which instead address concerns of health-care utilization and reimbursement. See also *American Progressive Life & Health Insurance Co. of New York v. Corcoran,* 715 F.2d 784 (2d Cir. 1983), in which the court held that a New York insurance regulation establishing a maximum commission for life insurance salesmen selling to ERISA plans was saved from the ERISA preemption because it was directed at the business conduct of the insurance company. This decision is entirely consistent with the traditional purposes of state insurance regulation to protect the policyholder—in that case the ERISA plan—from insurance company practices.

State laws, like Section 47B, which dictate the coverage that a policyholder must purchase, are not laws within the scope of traditional state insurance regulation. They are not aimed at protecting or regulating the relationship between the insurance company and the policyholder or at maintaining the insurance company's status as a reliable insurer. Rather they are aimed at financing and promoting the utilization of health care services by shifting the payment obligation away from the health care consumer. This is not insurance regulation but health care regulation.

Whatever Massachusetts' interest may be in protecting the interests of health care providers and consumers, it may not elevate this state interest above federal regulation of ERISA plans unless it can establish that this interest falls within one of the narrow exceptions to the ERISA preemption. This it has not done, and given the nature of Section 47B, this it cannot do.

The clear purpose of Section 47B is not to regulate the practices or activities of insurance companies for the protection of policyholders, but rather to use the financial resources of insurance companies, employers, unions and ERISA plans to promote the increased utilization of certain health care services and, not incidentally, to protect the financial interests of certain classes of health care providers.

Because Section 47B dictates the benefits to be provided by ERISA plans, federal law must prevail over state law, regardless of whether these plans are insured or uninsured. The determination of the benefit mix to be provided by such plans must be allowed to proceed under the protection of federal regulation and the collective bargaining process, unfettered by state law.

CONCLUSION

For the reasons stated, the decision of the Supreme Judicial Court for the Commonwealth of Massachusetts should be reversed.

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METROPOLITAN LIFE INSURANCE COMPANY,
Appellant,

v.

COMMONWEALTH OF MASSACHUSETTS,
Appellee.

THE TRAVELERS INSURANCE COMPANY,
Appellant,

v.

COMMONWEALTH OF MASSACHUSETTS,
Appellee.

On Appeal From The Supreme Judicial Court For The Commonwealth Of Massachusetts

BRIEF *AMICUS CURIAE* OF THE ERISA INDUSTRY COMMITTEE IN SUPPORT OF APPELLANTS

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

Nos. 84-325 and 84-356

METROPOLITAN LIFE INSURANCE COMPANY,
Appellant,

v.

COMMONWEALTH OF MASSACHUSETTS,
Appellee.

THE TRAVELERS INSURANCE COMPANY,
Appellant,

v.

COMMONWEALTH OF MASSACHUSETTS,
Appellee.

On Appeal From The Supreme Judicial Court For The Commonwealth Of Massachusetts

BRIEF *AMICUS CURIAE* OF THE ERISA INDUSTRY COMMITTEE IN SUPPORT OF APPELLANTS

The issue presented in this case is whether state legislatures are free, in the guise of "insurance regulation," to dictate the benefits that must be provided by insured employee benefit plans. This is an issue of paramount significance to the employees and employers of this Nation.

The decision below holds that a Massachusetts statute requiring particular mental health benefits to be included in all health insurance policies covering state residents—a statute expressly designed to prescribe the benefits to be provided by all employee health benefit plans in Massachusetts—is not pre-empted by the Employee Retirement Income Security Act of 1974 ("ERISA") or the National Labor Relations Act ("NLRA"). This result defeats a central purpose of ERISA and the NLRA—to reserve the regulation of employee benefit plans exclusively to federal law.

Unless reversed, the decision of the Massachusetts Supreme Judicial Court threatens to force employers either to assume the great burden and expense of conforming their insured employee benefit plans to ever-changing laws of fifty different states, or to abandon insured employee benefit plans altogether. Because of these grave consequences, the ERISA Industry Committee submits this *amicus curiae* brief urging reversal of the decision below. All parties have consented to the filing of this brief.

THE INTEREST OF THE *AMICUS CURIAE*

The ERISA Industry Committee ("ERIC") is a nonprofit association of over one hundred major corporations doing business in a wide variety of American industries. A list of ERIC's members is set forth in the Appendix hereto. Through ERIC, member companies express their views to the courts, the Congress and the Executive Branch on issues affecting private pension and welfare plans.

ERIC represents a broad cross-section of firms maintaining health benefit plans and other welfare plans for their employees.[1] ERIC members' welfare plans cover tens of millions of beneficiaries. Some of these plans are collectively-bargained, while others cover non-union employees.

[1] "Welfare plans" are employee benefit plans that provide non-pension benefits, such as health, accident or supplemental unemployment benefits. ERISA § 3(1), 29 U.S.C. § 1002(1); 29 C.F.R. § 2510.3-1.

All of the members of ERIC do business in more than one state, and a number have employees in all fifty states. Transfers of employees from one state to another are common. Many of the welfare plans of ERIC's members provide uniform benefits in all states where beneficiaries are located. Such nationwide benefit uniformity is important to employee morale and yields significant savings in administrative expenses.

Most of the welfare plans of ERIC's members are *insured plans*—that is, they provide benefits through the purchase of group insurance policies covering their beneficiaries. Under an insured plan, the employer pays a premium to the insurance company, and the insurance company generally assumes the risk as to the actual level of benefits that will be payable during the term of the policy.[2]

Some ERIC members maintain *non-insured plans.* Under these plans, the cost of benefits is the direct responsibility of the employer, who is sometimes referred to as a "self-insurer." As a rule, "self-insurance" is an economically feasible alternative to purchasing insurance from an insurance company only where a plan is large enough to allow the risk to be spread over a large population. While self-insurance has been growing, insured welfare plans remain much more common. For example, among medium and large firms nationwide, insured health plans covered about four times as many individuals as self-insured plans in 1982. U.S. DEPARTMENT OF LABOR, BUREAU OF LABOR STATISTICS, EMPLOYEE BENEFITS IN MEDIUM AND LARGE FIRMS, 1982, at 36 (1983).

[2] Some insurance policies, particularly for large plans, are "experience rated," which means that the premium is based on the actual claims experience under the policy. Generally, under such policies, if the plan has a surplus in a particular year (premiums exceed claims and expenses), the plan receives a refund or credit of some portion of the premiums, while if the plan incurs a deficit (claims and expenses exceed premiums), the employer can choose between not renewing the policy, in which case the insurance company absorbs the deficit, or renewing the policy and paying some or all of the deficit over a period of time. Under experience-rated policies of this kind, risks are not borne entirely by the insurance company, but rather are shared by the insurance company and the employer.

Whether state governments can dictate the benefits of insured welfare plans is a question of great importance to ERIC's members and their employees. Welfare-plan benefits are a major issue in collective bargaining negotiations and a major element in the compensation of non-union employees. The companies participating in ERIC spend hundreds of millions of dollars each year on insurance premiums and administrative expenses for insured welfare plans.[3] Laws increasing the costs of insured welfare plans can have a substantial economic impact on a business.

If the states are permitted to enforce a crazy quilt of mandatory-benefit laws against insured welfare plans, employees and employers alike will suffer. Companies that wish to maintain insured plans will be forced either (a) to adopt all-encompassing benefit packages that satisfy the laws of every state, which will greatly increase welfare-benefit costs and force curtailment of other elements of compensation, or (b) to provide a variety of different benefits on a state-by-state basis, which will impose costly administrative burdens and cause dissatisfaction and confusion among employees. Free give-and-take in collective bargaining over the compensation of union employees will be supplanted by state prescription of a key element of compensation, as will employers' ability to offer their non-union employees attractive pay and benefit packages at acceptable cost. Employees will be forced to accept benefits they would not have chosen themselves, and to sacrifice benefits they would have preferred. The only remaining alternative for employers with insured plans will be to abandon their insured plans altogether and shoulder the risks and costs of "self-insurance"—risks and costs they decided *not* to incur when they established insured plans.

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[3] Nationally, health insurance premiums totalled $85 billion in 1981, most of which was paid by employers. HEALTH INSURANCE ASSOCIATION OF AMERICA, SOURCE BOOK OF HEALTH INSURANCE DATA, 1982-1983, at 6 (1982). Some three-fourths of the full-time employees of private firms are covered by health plans. U.S. DEPARTMENT OF LABOR, LABOR-MANAGEMENT SERVICES ADMINISTRATION, GROUP HEALTH INSURANCE COVERAGE OF PRIVATE FULL-TIME WAGE AND SALARY WORKERS, 1979, at 15 (1981).

In sum, if the decision below is not reversed, both employees and employers will be prevented from achieving the best possible benefits at the most reasonable cost. The result will be that fundamental policies of ERISA—national uniformity in benefit-plan regulation and the growth and soundness of employee benefit plans—will be frustrated. The NLRA's policy of leaving the basic terms and conditions of employment of unionized employees to private collective bargaining also will be defeated. ERIC's members and their employees have a vital interest in the vindication of these important Congressional policies.

SUMMARY OF ARGUMENT

Massachusetts' mandated benefit statute is pre-empted by both ERISA and the NLRA.

The Massachusetts statute is pre-empted by ERISA because it was directed at employee benefit plans, not at insurance. ERISA's broad pre-emption provision supersedes all state laws relating to employee benefit plans. Uniform interstate employee benefit plans, which were the objective of ERISA's pre-emption provision, cannot flourish in an environment of varied and conflicting state regulations.

ERISA's insurance savings clause, which excepts laws that "regulate insurance" from pre-emption, does not apply to the Massachusetts statute. The Massachusetts court's literalistic reading of this clause to exempt from pre-emption any state law touching in any way on insurance would allow a narrow exception to consume the general rule; it would permit states to regulate employee benefit plans without any limitation, merely by adopting statutes that take the form of "insurance" laws. The insurance savings clause must instead be read in a fashion that harmonizes ERISA's primary purpose of barring piecemeal state regulation of employee benefit plans with ERISA's additional objective of preserving state insurance regulations that have secondary effects on employee benefit plans. The proper standard is one based on whether, taking account of its purpose and effect, the state law is primarily directed at employee

benefit plans or insurance. Since the Massachusetts statute was indisputably directed at regulating employee benefit plans and not at regulating the insurance industry, it is pre-empted by ERISA.

To the extent it applies to collectively-bargained employee benefit plans, the Massachusetts statute also is pre-empted by the NLRA. A state mandated benefit law that purports to override private union-management agreements concerning mandatory subjects of bargaining is pre-empted under *Local 24, International Brotherhood of Teamsters* v. *Oliver,* 358 U.S. 283 (1959). No exception to the *Oliver* pre-emption doctrine applies to such a statute. This Court has never determined whether there is a "health and safety" exception to the *Oliver* pre-emption doctrine, but even if some such exception exists it cannot possibly extend so far as to permit the states to supplant private bargaining over fundamental elements of compensation. The exception to *Oliver* pre-emption for matters that Congress has expressly committed to the states also does not apply to state mandated benefit laws, for the McCarran-Ferguson Act did not confer upon the states the power to prescribe employee benefit levels; moreover, ERISA's objective of uniformity in interstate benefit plans is inconsistent with such state legislation.

ARGUMENT

Section 47B of Chapter 175 of the Massachusetts General Laws requires that insurance policies providing hospital and surgical benefits for state residents also provide specified mental health benefits.[4] Section 47B requires that these same benefits be provided by "any employees' health and welfare fund which provides hospital expense and surgical expense benefits" in the state.

Thus, Section 47B mandates health benefits for *all employee benefit plans*—both insured and non-insured plans. That this was the express purpose of Section 47B is confirmed by the

[4] These include payment for sixty days' hospitalization in a mental hospital, benefits for hospitalization in a general hospital for mental or nervous conditions that are equal to the benefits provided for other illnesses, and $500 per year for certain out-patient mental health benefits.

available legislative material: the explanatory report of the joint committee that originated the bill makes clear that the committee's objective was to furnish mental health benefits for *employees.* MASS. GEN. COURT, JT. COMM. ON INSURANCE, ADVANCES IN HEALTH INSURANCE IN MASSACHUSETTS 1 (statute aimed at "the working person"), 3 (statute directed at "workers"), 4 (discussing employee group insurance policies) (1974).

The goal—and the effect—of Section 47B was *to govern employee benefit plans.* Section 47B was *not* a statute aimed at governing insurance companies, with only incidental or secondary effects on employee benefit plans. To the contrary, the Massachusetts legislature set out to regulate employee benefit plans and did so in unambiguous terms, addressing insurance simply as one step to that objective.

I. SECTION 47B IS PRE-EMPTED BY ERISA

ERISA pre-empts all state laws insofar as they "relate to any employee benefit plan." ERISA § 514(a), 29 U.S.C. § 1144(a). Exempted from this pre-emption, however, is any state law "which regulates insurance." *Id.* § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). (This is often referred to as the "insurance savings clause.") ERISA also provides that, in applying the insurance savings clause, an employee benefit plan shall not "be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts." *Id.* § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B). (This is often referred to as the "deemer clause.")

The question confronting the Massachusetts Supreme Judicial Court in this case was whether Section 47B was (a) exempt from pre-emption as a law "which regulates insurance" within the meaning of ERISA's insurance savings clause, or (b) pre-empted by ERISA's basic pre-emption provision, particularly when that provision is read in conjunction with the expression of Congressional intent in the deemer clause to prevent state insurance laws from being used as a pretext for state regulation of employee benefit plans.

The Massachusetts court answered this question twice—once in 1982, and then again in 1984 after a remand from this Court. In its initial decision, the court began its analysis by artificially bifurcating Section 47B. The Commonwealth had conceded that insofar as the statute required specified benefits to be provided by *non-insured* employee benefit plans, it was pre-empted by ERISA. The court concluded that this aspect of the statute was severable, as a matter of general state-law severability doctrine, from the clause addressing insurance policies, and thus proceeded to review Section 47B as if it had been enacted solely as a law concerning insurance. *Attorney General* v. *Travelers Insurance Co.*, 385 Mass. 598, 601, 433 N.E.2d 1223, 1225, App. 13a, 15a-16a (1982), *vacated & remanded,* 103 S. Ct. 3563, App. 10a (1983), *on remand,* 391 Mass. 730, 463 N.E.2d 548, App. 1a, *prob. juris. noted,* 105 S. Ct. 320 (1984).

The court recognized that a literal reading of ERISA's insurance savings clause, exempting any state law bearing the label "insurance" from federal pre-emption, was untenable, as this would give the states virtually unlimited rein to govern employee benefit plans under the pretext of insurance regulation. As the court put it, this construction "might permit the State, through its insurance laws, to reach far into areas governed by ERISA, and thereby negate the unmistakable intent of Congress to work a broad preemption." *Id.* at 606, 433 N.E.2d at 1228, App. at 21a.

The court was thus faced with the task of drawing a line between non-pre-empted state insurance laws and those state laws that, while dealing in some way with insurance, *are* pre-empted. The court decided that the correct basis for distinction was whether the state statute was in "clear conflict" with affirmative regulatory provisions of ERISA. *Id.* The court thought it could discern in this Court's decision in *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981), intimations that ERISA's pre-emption was aimed solely at state laws that "affected a subject covered by ERISA," and that pre-emption should therefore be found only where a state law conflicted directly with substantive provisions of ERISA. 385 Mass. at

608, 433 N.E.2d at 1229, App. at 23a. Applying this standard, the court concluded that Section 47B was not pre-empted because ERISA's *affirmative* regulation of welfare plans is limited to reporting, disclosure, fiduciary conduct and plan administration, and because ERISA, in contrast to Section 47B, does not prescribe the "substantive content of plans." *Id.* The court rejected the idea that ERISA was also actuated by fundamental policies of encouraging private initiative in structuring healthy, growing, broad-based employee benefit plans and allowing plan sponsors to enjoy a climate conducive to nationwide plan uniformity without interference from conflicting state laws. *Id.*

On appeal, 103 S. Ct. 3563, App. 10a (1983), this Court vacated and remanded for further consideration in light of *Shaw* v. *Delta Air Lines, Inc.*, 103 S. Ct. 2890 (1983). The opinion in *Shaw* stressed that the exceptions from pre-emption in ERISA are "narrow." *Id.* at 2902, 2903. The decision in *Shaw* also completely undermined both the Massachusetts Supreme Judicial Court's conflict-based notion of ERISA pre-emption and the Massachusetts court's rejection of private initiative and uniformity as fundamental goals of ERISA.

Shaw held that ERISA pre-empted a New York anti-discrimination law and a New York law requiring that sick-leave benefits be paid to employees unable to work because of pregnancy. The Court specifically noted that ERISA "does not mandate that employers provide any particular benefits, and does not itself proscribe discrimination in the provision of employee benefits." *Id.* at 2897. Nonetheless, the Court found the New York statutes pre-empted by ERISA's broad pre-emption of any state law that "relates to" employee benefit plans—thus rejecting the notion of the Massachusetts court in this case that conflict with affirmative provisions of ERISA is the necessary predicate for pre-emption.

Further, *Shaw* cited *Alessi* for the proposition that ERISA, in "establishing benefit plan regulation 'as exclusively a federal concern,'" was aimed at minimizing "the need for interstate employers to administer their plans differently in each State in which they have employees." *Id.* at 2904 (quoting *Alessi,* 451 U.S. at 523). *Shaw* pointed out that allowing "varied and

perhaps conflicting" state laws to be enforced against employee benefit plans would undercut employers' freedom to administer efficient, uniform employee benefit plans and would leave employers with a series of unattractive options. Among these options would be setting up different plans in each state—with "the inefficiency of such a system presumably . . . paid for by lowering benefit levels"—and adopting uniform plans that met the requirements of all states—which would require the employer to "reduce wages or eliminate those benefits not required by any State" in order to "offset the additional expenses." *Id.* at 2904 n.25. These very same adverse consequences are the inevitable result of the Massachusetts court's decision in this case.

On remand, however, despite the clear rejection in *Shaw* of the Massachusetts Supreme Judicial Court's earlier reasoning, that court refused to alter its decision. *Shaw*'s repeated characterization of ERISA's pre-emption exceptions as "narrow" was dismissed as "dictum," and the Supreme Judicial Court instead insisted on its own view of the insurance savings clause as "broad." 391 Mass. at 733-35, 463 N.E.2d at 550-51, App. at 4a-6a. The court acknowledged that *Shaw* "rejected a conflict-based analysis" of ERISA's general pre-emption provision, but nonetheless reaffirmed (though it did not rely upon) its own conflict-based theory of ERISA's insurance savings clause. *Id.* at 734, 463 N.E.2d at 551, App. at 5a. Finally, while conceding that it was required to "accept as authoritative" this Court's conclusion in *Shaw* that ERISA was intended to foster private initiative and uniformity in benefit plans, the Massachusetts Supreme Judicial Court reversed course and treated these policies as irrelevant. *Id.* at 734, 463 N.E.2d at 551, App. at 6a. While in its earlier decision the court had recognized that ERISA's insurance savings clause cannot be applied literally, and had sought to interpret the clause based on the court's views of the policies animating ERISA, now, faced with an authoritative Supreme Court decision rejecting its notions of Congress' intent, the Massachusetts court set aside intent and reaffirmed its prior decision based simply on the "language" of the insurance savings clause —language the court had previously recognized to be the

beginning, not the end, of the analysis. *Id.* at 735, 463 N.E.2d at 551, App. at 6a.

The court below erred in finding that Section 47B is not pre-empted by ERISA. The Massachusetts court's original "conflict-based" approach to the insurance savings clause was clearly discredited by *Shaw,* and was effectively abandoned on remand. But the Court's ultimate literalist reading of the clause—a reading that the court itself had initially described as converting a limited exception into a limitless loophole—is equally untenable.

The Massachusetts court's literalist construction of the insurance savings clause allows basic policies behind ERISA to be defeated by statutes that are labelled "insurance regulation" but are actually aimed at governing employee benefit plans. This cannot be permitted, for, as this Court said in *Alessi,* "ERISA's authors clearly meant to preclude the States from avoiding through form the substance of the pre-emption provision." 451 U.S. at 525; *see also SEC* v. *National Securities, Inc.,* 393 U.S. 453, 460 (1969).[5] The words of a Congressional statute must be interpreted " 'in light of the purposes Congress sought to serve.' " *Dickerson* v. *New Banner Institute, Inc.,* 460 U.S. 103, 118 (1983) (quoting *Chapman* v. *Houston Welfare*

[5] Contrast, for example, this case with *Hewlett-Packard Co.* v. *Barnes,* 425 F. Supp. 1294 (N.D. Cal. 1977), *aff'd,* 571 F.2d 502 (9th Cir.), *cert. denied,* 439 U.S. 831 (1978); *Standard Oil Co.* v. *Agsalud,* 442 F. Supp. 695 (N.D. Cal. 1977), *aff'd,* 633 F.2d 760 (9th Cir. 1980), *aff'd mem.,* 454 U.S. 801 (1981); *St. Paul Electrical Workers Welfare Fund* v. *Markman,* 490 F. Supp. 931 (D. Minn. 1980); *Stone & Webster Engineering Corp.* v. *Ilsley,* 518 F. Supp. 1297 (D. Conn. 1981), *aff'd,* 690 F.2d 323 (2d Cir. 1982), *aff'd mem.,* 103 S. Ct. 3564 (1983); and *General Split Corp.* v. *Mitchell,* 523 F. Supp. 427 (E.D. Wis. 1981), decisions that held that ERISA's pre-emption provision barred California, Hawaii, Minnesota, Connecticut and Wisconsin statutes that dictated various aspects of the health benefit coverage to be provided by employee benefit plans in each state. If the decision below were correct, these states could have circumvented the decisions in these cases simply by rewriting their statutes in the form of "insurance regulation."

Rights Organization, 441 U.S. 600, 608 (1979)) (cited in *Shaw,* 103 S. Ct. at 2900).[6] Congress' purpose in Section 514 of ERISA was to make certain that the only laws that would govern employee benefit plans would be federal laws. Congress thereby sought to promote uniformity in the terms of those plans and to foster their growth through private initiative, unfettered by restrictive or conflicting state regulations. *Shaw,* 103 S. Ct. at 2904. To be certain to achieve this purpose, Congress adopted a pre-emption provision "virtually unique" in its breadth (*Franchise Tax Board* v. *Construction Laborers Vacation Trust,* 103 S. Ct. 2841, 2854 n.26 (1983))—a provision pre-empting any state law that would even "relate to" employee benefit plans.

It was in this context that Congress made a "narrow" exception (*Shaw,* 103 S. Ct. 2902, 2903) for any state law "which regulates insurance." Perhaps in some other context it might be linguistically permissible to describe any law dealing in any way with insurance as a law "which regulates insurance." But in *this* context, reading the statutory language "in light of the purposes Congress sought to serve," such an interpretation is *not* permissible. Such a construction would allow a state law whose primary object is to govern employee benefit plans to prevail over Congress' central purpose of reserving the governance of such plans to federal law. This would give the states unlimited power to regulate insured

[6] *See also Azzaro* v. *Harnett,* 414 F. Supp. 473 (S.D.N.Y. 1976), *aff'd mem.,* 553 F.2d 93 (2d Cir.), *cert. denied,* 434 U.S. 824 (1977) (in light of Congress' broad pre-emptive purpose in enacting ERISA § 514, exception in subsection (b)(1) for "any cause of action which arose, or any act or omission which occurred, before January 1, 1975" cannot be construed as leaving states with ongoing power to investigate present benefit status of persons whose benefits accrued before January 1, 1975); *Health Care Plan of New Jersey, Inc.* v. *Schweiker,* 553 F. Supp. 440, 444-47 (D.N.J. 1982), *aff'd mem.,* 707 F.2d 1391 (3d Cir.), *cert. denied,* 104 S. Ct. 71 (1983) (analyzing pre-emption under Health Maintenance Organization Act of 1973, 42 U.S.C. § 300e-10, in terms of Congressional purposes); *SEC* v. *Variable Annuity Life Ins. Co.,* 359 U.S. 65, 80 (1959) (Brennan, J., concurring); *United States* v. *American Trucking Ass'ns, Inc.,* 310 U.S. 534, 543 (1940); *United States* v. *Turkette,* 452 U.S. 576, 580 (1981); *Sorrells* v. *United States,* 287 U.S. 435, 450 (1932).

employee benefit plans, even though ERISA specifically recognizes the primary role played by insured plans by defining "employee welfare benefit plan" as one that provides benefits "through the purchase of insurance or otherwise." ERISA § 3(1), 29 U.S.C. § 1002(1). Thus, here, as is often true of pre-emption savings clauses, "a literal application of the clause would not serve the statutory purpose." Hirsch, *Toward a New View of Federal Preemption,* 1972 U. ILL. L.F. 515, 540-41.

An appropriate interpretation of the insurance savings clause must recognize that Congress meant to leave traditional insurance regulation to the states—regulation, for example, of capitalization, fiduciary and investment standards, the form of policies and sales practices—but not to leave the states free to adopt laws formally classified as insurance laws yet having the primary purpose and effect of governing employee benefit plans. Construing the insurance savings clause in this way clearly requires pre-emption of the present statute—which was directly and explicitly aimed at employee benefit plans [7]—while leaving the states free to enact insurance laws with secondary or incidental effects on employee benefit plans.[8]

Under a proper reading of Section 514 of ERISA, if a state statute in some way concerns insurance and also "relates to" employee benefit plans, the pre-emption analysis must turn on the statute's overall object, considered in light of its purpose

[7] ERISA's pre-emption provisions are directed at state laws that regulate "the terms and conditions of employee benefit plans." ERISA § 514(c)(2), 29 U.S.C. § 1144(c)(2). This is exactly the intent and result of Section 47B. The Massachusetts Supreme Judicial Court's bifurcation of the statute disregarded this fact, and failed to come to grips with the *federal-law* statutory interpretation question—independent of any state-law severability issue—of whether, in light of its purpose and effect, Section 47B can be considered a law "which regulates insurance" within the meaning of ERISA's insurance savings clause. *Cf. SEC* v. *Variable Annuity Life Ins. Co.,* 359 U.S. 65 (1959) (variable annuity contracts are not "insurance" within the meaning of the McCarran-Ferguson Act and other federal statutes, despite their treatment as "insurance" in the insurance statutes of several states).

[8] Thus, contrary to the assertion in *Wadsworth* v. *Whaland,* 562 F.2d 70, 78 (1st Cir. 1977), *cert. denied,* 435 U.S. 980 (1978), a proper interpretation of the insurance savings clause does not "emasculate" the clause; it prevents the savings clause from emasculating ERISA's basic pre-emption provision.

and effect. Pre-emption should be found where the statute is principally directed at governance of employee benefit plans, and not where it is principally directed at regulation of insurance. Only in the latter case can the statute properly be considered one "which regulates insurance" within the meaning of ERISA's insurance savings clause.

This standard, unlike the lower court's literalist rule, harmonizes ERISA's primary mandate of pre-emption with the "narrow" exception made by the insurance savings clause.[9] And it is the only standard that can be squared with Congress' intent in enacting Section 514 of ERISA. The deemer clause clearly demonstrates a Congressional concern that the insurance savings clause not become a pretext for state action evading ERISA's establishment of "benefit plan regulation 'as exclusively a federal concern'" (*Shaw,* 103 S. Ct. at 2904 (quoting *Alessi,* 451 U.S. at 523)). The legislative history confirms that ERISA's pre-emption provisions were adopted in order to preclude "multiple," "conflicting," and "inconsistent" state laws regulating employee benefit plans. *See* 120 CONG. REC. 29197, 29933, 29942 (1974) (remarks of Rep. Dent, Sen. Williams and Sen. Javits) (quoted in *Shaw,* 103 S. Ct. at 2901 & n.20).[10]

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[9] *Accord, Michigan United Food & Commercial Workers Fund* v. *Baerwaldt,* 572 F. Supp. 943 (E.D. Mich. 1983), *appeal docketed,* No. 83-1570 (6th Cir. Aug. 16, 1983); Hutchinson & Ifshin, *Federal Preemption of State Law Under the Employee Retirement Income Security Act of 1974,* 46 U. CHI. L. REV. 23, 66-69 (1978).

[10] Moreover, a Congressional committee with responsibility for ERISA, including among its members principal sponsors of the statute, declared in a report on ERISA pre-emption issued shortly after ERISA's enactment that "the Federal interest and the need for uniformity are so great that enforcement of state regulation should be precluded," and suggested that this policy was threatened by unduly broad constructions of "our efforts to ensure *minimum* disruption to the regulatory efforts of the states in the fields of insurance, banking and securities." ACTIVITY REPORT OF THE HOUSE COMMITTEE ON EDUCATION AND LABOR, H.R. REP. NO. 1785. 94th Cong., 2d Sess. 47 (1977) (emphasis added). The committee's reference to "minimum" disruption of state regulation indicates that a literalist reading of the insurance savings clause, permitting *no* disruption of state laws dealing with insurance, was not intended. The committee's report is entitled to significant weight in construing the insurance savings clause. *See, e.g., Bell* v. *Employee Security Benefit Ass'n,* 437 F. Supp. 382, 392 (D. Kan. 1977); *Hamberlin* v. *VIP Ins. Trust,* 434 F. Supp. 1196, 1199 (D. Ariz. 1977).

Therefore, because there can be no doubt, upon consideration of both the purpose and effect of Section 47B, that it was directed at the governance of employee benefit plans rather than at the regulation of insurance, the Court should hold that Section 47B is pre-empted by ERISA.

II. SECTION 47B, AS APPLIED TO COLLECTIVELY-BARGAINED EMPLOYEE BENEFIT PLANS, IS PRE-EMPTED BY THE NLRA

Insofar as it applies to collectively-bargained plans, Section 47B also is pre-empted by the NLRA.

Many insured welfare plans are collectively bargained. Section 47B undeniably intrudes on the freedom of unions and management to negotiate the terms of employment contracts. The impact is significant. Health benefits are a principal issue in labor negotiations. State-mandated benefits of one kind often force workers to sacrifice other, preferred benefits of a different kind.

In *Local 24, International Brotherhood of Teamsters* v. *Oliver,* 358 U.S. 283, 296-97 (1959), this Court held that the NLRA, by guaranteeing the right to private determination of the terms of collective bargaining agreements, pre-empts state laws that purport to prescribe such terms. Health benefits are a mandatory subject of bargaining. *Allied Chemical & Alkali Workers* v. *Pittsburgh Plate Glass Co.,* 404 U.S. 157, 159 (1971). Thus, *Oliver* squarely stands for the conclusion that the NLRA pre-empts Section 47B as applied to collectively-bargained insured plans.

This conclusion is supported by the Court's decision in *Alessi, supra.* There, in determining that ERISA pre-empted state laws prohibiting workers' compensation benefits from being offset against pensions, the Court, citing *Oliver,* stated that its holding was reinforced, insofar as collectively-bargained pension plans were concerned, by "the additional federal interest in precluding state interference with labor-management negotiations." 451 U.S. at 525. Pre-emption was compelled, the Court held, by the "direct clash between the state statute and the federal policy to keep calculation of pension benefits a

subject of either labor-management negotiations or federal legislation." *Id.* at 526 n.22. *See also Malone* v. *White Motor Corp.*, 435 U.S. 497 (1978) (plurality opinion); *Connell Construction Co.* v. *Plumbers & Steamfitters Local Union No. 100*, 421 U.S. 616 (1975).

The Massachusetts Supreme Judicial Court cited two reasons for finding that Section 47B was not pre-empted by the NLRA. First, the court found that there was a "public health" exception to NLRA pre-emption. The court reached this conclusion based on a remark in *Oliver* (358 U.S. at 297) that the state law pre-empted in that case was not a "local health or safety regulation." 385 Mass. at 613, 433 N.E.2d at 1232, App. at 29a-30a. Second, the court concluded that there is no NLRA pre-emption where some other federal statute expresses a Congressional intent to permit state regulation. The court found such an intent in Section 2(b) of the McCarran-Ferguson Act, 15 U.S.C. § 1012(b), which provides that federal statutes should not be construed as superseding state laws enacted "for the purpose of regulating the business of insurance." 385 Mass. at 613-14, 433 N.E.2d at 1232, App. at 30a.

This Court has never held that there is a "public health" exception to the *Oliver* doctrine. Even if there were such an exception, it could not possibly reach so far as to permit states to dictate fundamental terms of collective bargaining agreements. If welfare-benefit terms of labor contracts were within a reserved state power to regulate "public health," it is difficult to see why every element of compensation would not come within such an exception. Such a doctrine would permit unlimited state control of collective bargaining.

Similarly, this Court has never held that the McCarran-Ferguson Act, which was enacted long before state legislatures first attempted to prescribe substantive terms of collective bargaining agreements through the vehicle of "insurance" laws, expresses a Congressional intent to permit such state legislation. The recent decision in *Malone* v. *White Motor Corp., supra*, indicates that any such intent must be "evident." 435 U.S. at 513 (plurality opinion); *see also New York Telephone Co.* v. *New York State Department of Labor*, 440 U.S. 519, 540-45

(1979) (plurality opinion); *id.* at 546 n.* (Brennan, J., concurring); *id.* at 547, 551 (Blackmun, J., concurring); *SEC* v. *Variable Annuity Life Insurance Co.*, 359 U.S. 65, 80 (1959) (Brennan, J., concurring); *Maryland Casualty Co.* v. *Cushing*, 347 U.S. 409, 412-13 (1954). This is a test that the court below did not apply and that there is no reason to believe the McCarran-Ferguson Act can pass. *See SEC* v. *National Securities, Inc.*, 393 U.S. 453, 458-59 (1969) (in enacting the McCarran-Ferguson Act in 1945, "Congress was mainly concerned with the relationship between insurance ratemaking and the antitrust laws, and with the power of the states to tax insurance companies," and did not intend to confer upon the states any power to regulate insurance that they had not previously been held to possess). Moreover, for the reasons already discussed above in connection with ERISA pre-emption, a statute enacted with the express purpose of regulating employee benefit plans cannot properly be regarded as a statute adopted "for the purpose of regulating the business of insurance."[11] Finally, Section 4 of the McCarran-Ferguson Act, 15 U.S.C. § 1014, expressly provides that the Act shall not affect "application [of the NLRA] to the business of insurance"; the Massachusetts court's notion that this provision was directed solely at application of the NLRA to insurance-firm employees and not to other interactions between the NLRA and state insurance laws (385 Mass. at 614 n.25, 433 N.E.2d at 1232 n.25, App. at 30a n.25) seems to be entirely that court's creation, without support in either the language or the legislative history of Section 4.

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[11] *Cf. Group Life & Health Ins. Co.* v. *Royal Drug Co.*, 440 U.S. 205 (1979) (Blue Shield Pharmacy Agreements, which are referred to in Blue Shield insurance contracts to determine the level of reimbursement for prescription drugs, are not exempt from antitrust laws as "the business of insurance" under the McCarran-Ferguson Act, particularly in light of the principle that exemptions from the antitrust laws are to be narrowly construed); *Union Labor Life Ins. Co.* v. *Pireno*, 458 U.S. 119 (1982) (same: rendering of opinions by chiropractors' peer review committee concerning whether particular services are covered by insurance policies).

Accordingly, neither of the grounds cited by the lower court for disregarding *Oliver* has merit, and this Court should hold that Section 47B, as applied to collectively-bargained plans, is pre-empted by the NLRA.[12] This issue need not be reached, however, if the Massachusetts Supreme Judicial Court's holding as to ERISA pre-emption is reversed.

CONCLUSION

The decision below should be reversed.

Respectfully submitted,

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December 20, 1984

[12] *Accord*, Hutchinson & Ifshin, *supra* note 9, at 74-75; *see also Blue Cross & Blue Shield of Alabama* v. *Peacock's Apothecary, Inc.*, 567 F. Supp. 1258, 1277 (N.D. Ala. 1983).

APPENDIX

MEMBERS OF THE ERISA INDUSTRY COMMITTEE

Aetna Life and Casualty Company

Alexander & Alexander Services, Inc.

Allied Corporation

Aluminum Company of America

AMAX Inc.

American Telephone & Telegraph Company

Apache Corporation

ASARCO Incorporated

Atlantic Richfield Company

Bankers Trust Company

Bank of America N.T. & S.A.

Bell Communications Research

Bell South Corporation

Bethlehem Steel Corporation

The Boeing Company

Bristol-Myers Company

Buck Consultants, Inc.

Caterpillar Tractor Co.

Champion International Corporation

The Chase Manhattan Bank, N.A.

Ciba-Geigy Corporation

Citibank, N.A.

The Coca-Cola Company

Columbia Gas System Service Corp.

Combustion Engineering, Inc.

Connecticut General Life Insurance Co.

Consolidated Foods Corporation

The Continental Group, Inc.

Coopers & Lybrand

Dart & Kraft Inc.

Deere & Company

Delta Air Lines Inc.

Digital Equipment Corp.

R. R. Donnelley & Sons Company

The Dow Chemical Company

Dresser Industries, Inc.

E. I. du Pont de Nemours & Company, Incorporated

Eastman Kodak Company

Eli Lilly and Company

Equitable Life Assurance Society of the United States

Esmark, Inc.

Exxon Corporation

Federated Department Stores, Inc.

FMC Corporation

Ford Motor Company

General Electric Company

General Mills, Inc.

General Motors Corporation

W. R. Grace & Co.

The Greyhound Corporation

Grumman Corporation

GTE Corporation

Gulf & Western Industries, Inc.

Frank B. Hall Consulting Company

John Hancock Mutual Life Insurance Co.

A. S. Hansen, Inc.

Hazlehurst & Associates, Inc.

H. J. Heinz Company

Hewitt Associates

Honeywell Inc.

ICI Americas, Inc.

Ingersoll-Rand Company

International Business Machines Corporation

International Harvester Company

International Telephone & Telegraph Corporation

Internorth, Inc.

Johnson & Higgins, Inc.

Johnson & Johnson

Knight-Ridder Newspapers, Inc.

The LTV Corporation

Manufacturers Hanover Trust Company

William M. Mercer, Inc.

Metropolitan Life Insurance Company

Minnesota Mining & Manufacturing Co.

Mobil Oil Corporation

Monsanto Company

Mutual of America

NYNEX Corporation

Occidental Petroleum Services, Inc.

Olin Corporation

Owens-Corning Fiberglas Corporation

Owens-Illinois, Inc.

J. C. Penney Company, Inc.

Pennzoil Company

PPG Industries, Inc.

Procter & Gamble Company

The Prudential Insurance Company of America

Ralston Purina Company

RCA Corporation

Republic Steel Corporation

R. J. Reynolds Industries, Inc.

Rockwell International Corporation

Sears, Roebuck and Co.

Shell Oil Company

The Southland Corporation

Sperry Corporation

Standard Oil Company of California

Standard Oil Company of Indiana

Standard Oil Company of Ohio

Sun Company. Inc.

Tampa Electric Company

Tenneco Inc.

Texaco Inc.

Textron Inc.

Time Incorporated

Towers, Perrin, Forster & Crosby Inc.

The Travelers Insurance Company

TRW Inc.

Union Camp Corporation

Union Carbide Corporation

United States Steel Corporation

United States Tobacco Company

United Technologies Corporation

Unocal Corporation

Westinghouse Electric Corporation

The Wyatt Company

Xerox Corporation

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I certify that on this 20th day of December 1984 I served the foregoing brief on each of the parties by sending three copies thereof by first-class mail, postage prepaid, to:

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

METROPOLITAN LIFE INSURANCE COMPANY,
Appellant

v.

COMMONWEALTH OF MASSACHUSETTS,
Appellee

THE TRAVELERS INSURANCE COMPANY,
Appellant

v.

COMMONWEALTH OF MASSACHUSETTS,
Appellee

On Appeals from the Supreme Judicial Court of Massachusetts

BRIEF AMICUS CURIAE OF THE NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS IN SUPPORT OF APPELLANTS

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IN THE

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METROPOLITAN LIFE INSURANCE COMPANY,
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COMMONWEALTH OF MASSACHUSETTS,
Appellee

On Appeals from the Supreme Judicial Court of Massachusetts

BRIEF AMICUS CURIAE OF THE NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS

The National Coordinating Committee for Multiemployer Plans submits this brief *amicus curiae* in support of Appellants. Copies of letters written by counsel for Appellants and Appellee granting the parties' consent to this submission are on file with the Clerk of the Court.

INTEREST OF THE NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS

The National Coordinating Committee for Multiemployer Plans (the "NCCMP"), pursuant to the written consent of the parties, submits this brief urging reversal of the decision of the Supreme Judicial Court of Massachusetts that a State statute requiring insured employee benefit plans to provide particular medical benefits is not preempted by section 514 of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1144. The NCCMP is a nonprofit, tax-exempt organization formed after the enactment of ERISA to participate in the development of employee benefit legislation and government regulations under ERISA and other laws affecting multiemployer plans. More than 140 multiemployer plans and related international unions are affiliated with the NCCMP. These plans are representative of all the nation's multiemployer plans, covering more than eight million workers. The NCCMP's affiliates together represent the majority of participants in such plans.

As set forth in this brief, the NCCMP submits that the decision below directly contravenes the national employee benefits policy established by Congress and consistently upheld by this Court. Consequently, the decision of the Supreme Judicial Court of Massachusetts will have a significant adverse effect upon the nation's multiemployer plans and the health and welfare of the millions of such plans' participants. The NCCMP is concerned that the failure to reverse the State supreme court's decision would discourage the establishment and continuance of multiemployer benefit plans, which, by definition, are created and maintained pursuant to the collective bargaining process.

Because multiemployer plans cover workers in broad geographical areas and typically span State lines, anything less than a reversal of the decision below would

wholly frustrate multiemployer plan trustees who would be forced to administer plans pursuant to a disarray of potentially conflicting State laws. Plan trustees would be unable to avoid the chaotic result of fifty-one jurisdictions enacting numerous, differing laws dictating which benefits the plans must provide. State mandated benefit statutes, like Section 47B of Massachusetts General Laws, Chapter 175 (hereinafter "Section 47B"), profoundly affect the structure, administration, and type of benefits provided by plans. The power to mandate plan benefits is the functional equivalent of the power to mandate plan costs, *i.e.*, employer contributions to fund the benefits. Moreover, the exercise of such power by a State government would outright remove the terms of benefit plans from the collective bargaining process, the sole context in which multiemployer plans are created and maintained. In the name of regulating "insurance", the Commonwealth of Massachusetts seeks to eviscerate ERISA's preemption clause, thereby threatening the growth and stability of multiemployer benefit plans.

SUMMARY OF REASONS FOR REVERSAL

A. Consistent with established Congressional policy and the express interpretation of ERISA by its drafters, this Court has declared that ERISA's preemption of State laws is to be sweeping, and its exceptions to preemption narrow. *Shaw v. Delta Air Lines, Inc.* (*"Shaw"*), 51 U.S.L.W. 4968 (U.S. June 21, 1983); *Alessi v. Raybestos-Manhattan, Inc.* (*"Alessi"*), 451 U.S 504 (1981). By virtue of this clear policy of federal preemption, this Court has refused to permit State regulation of employee benefit plans either directly or indirectly. *Id.*; *Agsalud v. Standard Oil Co. of California* (*"Agsalud"*), 633 F.2d 760 (9th Cir. 1980), *aff'd mem.*, 454 U.S. 801 (1981). Yet, contrary to these fundamental principles, the court below attempts to make benefit plans a subject of State regulation, thereby maximizing the burden of interstate

plan administration and minimizing the salutary Congressional purposes of federal preemption. Furthermore, the lower court's decision to uphold a mandated benefit statute like Section 47B is completely at odds with the view of Congress that only by expressly amending ERISA could there be an exemption from preemption of a State insurance law mandating specific benefits to be provided by employee plans. Title III, § 301(a) of the Periodic Payment Settlement Act, Pub. L. 97-473, 96 Stat. 2605, 2611 (1983).

B. In reaching its decision that Section 47B was not preempted by ERISA, the high court of the Commonwealth held the scope of ERISA's preemption to be limited solely to State laws which squarely conflict with the subject matter covered by ERISA. Subsequent to the State court decision, this Court in *Shaw* rejected such a "conflict analysis", 51 U.S.L.W. at 4970-72. Although this Court remanded the instant cases to the State court for review in light of *Shaw*, on remand the State court turned a deaf ear to the opinions of this Court and reverted to the "conflict analysis." Moreover, recognizing that the decision below is directly inapposite to the most recent enunciation by this Court of the scope and underlying purpose of federal preemption under ERISA, *Shaw*, *supra*, the Appellee is forced to resurrect the discredited argument it made below that any State statute which applies to insurance is saved from preemption. (J.S. App. D, 21a).[1] However, this "insurance" argument was not only expressly rejected below by the Supreme Judicial Court of Massachusetts, *id.*, but it also conflicts with decisions of this Court and the express intent of Congress. *See*, *Shaw*, *supra*; *Alessi*, *supra*; and *Agsalud*, *supra*.

---

[1] "J.S. App." refers to the separately bound appendix filed jointly in this Court by the Appellants in the instant cases.

REASONS FOR REVERSAL

A. The decision below conflicts with ERISA's preemption clauses, as construed in the contemporaneous and subsequent legislative history interpreting the statute.

The legislative history of ERISA reflects a profound Congressional insight as to the problems that would be faced by employee benefit plans which operate across State lines, were such plans obligated to comply with varying State laws regulating the structure and terms of the plans. *See, e.g., Shaw, supra,* 51 U.S.L.W. at 4973. Congress sought to alleviate the potential for chaos by enacting a broad preemption provision as part of ERISA. Moreover, "ERISA's authors clearly meant to preclude States from avoiding through form the substance of the preemption program." *Alessi, supra,* 451 U.S. at 525.

The federal statute's authors went on the record to "make it clear that a State insurance law which requires that a particular benefit be provided by an insurer selling policies to employee benefit plans covered by ERISA is preempted and is not saved from preemption by the exception for State laws which regulate the insurance industry." 125 *Cong. Rec.* 931 (1979) (remarks of Sen. Williams). *See, id.,* at 947 (remarks of Sen. Javits). These Senators—not only principal proponents of ERISA from its genesis but also leaders of the Conference Committee which ultimately drafted the sweeping preemption language of ERISA— took the position that any State statute mandating benefits is preempted because it is a law which "relates to any employee benefit plan", ERISA Section 514(a), 29 U.S.C. § 1144(a); ERISA's drafters flatly rejected the proposition that such a State statute is a law which "regulates insurance", ERISA Section 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). *See,* Hearings before the Committee on Labor and Human Resources, United States Senate, 96th Cong., 1st Sess. on S. 209, *passim* (1979).

This Court acknowledges that when Congress chose to preempt all State laws that "relate to any employee benefit plan", ERISA Section 514(a), 29 U.S.C. § 1144(a), "Congress used the words 'relate to' . . . in their broad sense", *Shaw*, supra, 51 U.S.L.W. at 4971, thereby "creating only very limited exceptions to preemption," *id.* at 4972. By establishing employee benefit plan regulation "as exclusively a federal concern," *Alessi, supra*, 451 U.S. at 523, the drafters of ERISA believed they had "eliminat[ed] the threat of conflicting and inconsistent State and local regulation." 120 *Cong. Rec.* 29197 (1974) (remarks of Rep. Dent). *See, id.* at 29933 (remarks of Sen. Williams).

Consistent with the express intent of ERISA's drafters, this Court has affirmed that ERISA preempts the mandated benefit provisions of the Hawaii Prepaid Health Care Act ("HPHCA"), *Agsalud, supra*, to the extent the HPHCA affects employee plans. For, "[t]o hold that a state health insurance law does not regulate directly or indirectly the terms and conditions of employee benefit plans would distort the meaning of those words [in ERISA Section 514(a)] beyond recognition." *Agsalud, supra*, 633 F.2d at 767. *Accord, Alessi, supra*, 451 U.S. at 525.

The Congressional response to the ruling in *Agsalud* squarely ratified the judiciary's interpretation of ERISA. Recognizing that the law had been correctly construed in *Agsalud*, but desiring to preserve the HPHCA, Congress enacted a specific exception to ERISA Section 514 for that sole and express purpose. Title III, § 301(a) of the Periodic Payment Settlement Act of 1982, Pub. L. 97-473, 96 Stat. 2605, 2611 (1983), adding Section 514(b)(5), 29 U.S.C. § 1144(b)(5), to ERISA.[2]

[2] It is worthy of note that the Hawaii Act specifically permits employees to bargain collectively with their employers for health benefits that may differ from those specified in the law. Thus, even though the enactment of the HPHCA exception lifted the veil of preemption ever so slightly, in so doing, Congress restated its desire for preservation of benefit plans negotiated through the collective bargaining process.

Furthermore, last term this Court held that New York may not enforce its insurance laws "through regulation of ERISA-covered benefit plans." *Shaw, supra*, 51 U.S.L.W. at 4974. In that case, this Court concluded that Congress, in enacting ERISA, intended to encourage uniform, interstate employee plans by choosing to preempt conflicting and inconsistent State and local regulations.

Against this backdrop, the Supreme Judicial Court of Massachusetts noted the conclusions reached by this Court in *Shaw*, but refused to find the State mandated benefit law preempted. The State court instead held that Congressional intent enunciated by this Court in *Shaw* was "inconsistent with the broad language of the insurance exception." (J.S. App. A, 6a). But, the statutory language the State court denominated as "broad", has been referred to by this Court in *Shaw* as "narrow" and "limited", 51 U.S.L.W. at 4972. And, although this Court holds that the federal government, through ERISA, has left to the discretion of the private parties that create the plan the determination of what benefits a plan should contain, *Alessi, supra*, 451 U.S. at 511, 525, the court below clings to the view that such control reposes with the State. The State court simply fails to acknowledge "the direct clash between the state statute and the federal policy to keep the calculation of [plan] benefits a subject of either labor-management negotiations or federal legislation," *Alessi, supra*, 451 U.S. at 526, n.22. *See, id.*, at 525.

The adverse consequences of the lower court's ruling are evident. Even the insurance commissioners of the fifty States recognize the Congressional determination that employee benefit plans "have become an important

factor in commerce because of the interstate character of their activities," ERISA Section 2(a), 29 U.S.C. § 1001(a), and acknowledge inherent dangers in interfering with the

> federal interest in uniform regulation of employee benefit plans . . . .
>
> [T]he imposition of mandatory benefits may increase health care costs of employee benefit plans . . . . [M]andatory health benefit laws may impose administrative burdens on employee benefit plan managers attempting to comply with varying state requirements. A third problem which diverse mandated benefits may create for employee benefit plans is the impact of such benefits on industrial relations. If different levels of benefits are provided to the employees in different states it is possible that employers [unions, and plan trustees] will be accused of being unfair in offering benefits to employees in some states while not offering those same benefits to employees in other states.

Statement of the National Association of Insurance Commissioners ("NAIC")[3] on S. 209 at 3, presented to the Committee on Labor and Human Resources, United States Senate, March 22, 1979. Thus, it is clear that the lower court's decision upholding a mandated benefit statute serves to weaken the multiemployer plan system, which Congress has consistently sought to nurture. ERISA Section 2(a), 29 U.S.C. § 1001(a).

The merits of the individual State law in question are irrelevant in deciding to what extent preemption should be extended or circumscribed. To hold that the insurance saving clause of ERISA Section 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A), preserves one mandated benefit law—whatever its merits—would be to foster nonuniformity, and conjure up the nightmare of at least fifty-one differing and conflicting laws. The impact of the decision below simply runs counter to ERISA's aim of national harmony in plan regulation. *Shaw, supra,* 51 U.S.L.W. at 4971, n.20 and 4973, n.25. *See, Mich. United Food & Com. Wkr. Unions v. Baerwaldt,* 572 F. Supp. 943, 948-51 (E.D. Mich), *appeal docketed,* No. 83-1570 (6th Cir. Aug. 16, 1983).

[3] The NAIC is a voluntary association of the principal insurance regulatory officials of the fifty states, the District of Columbia, Guam, and Puerto Rico. The NAIC has recognized the "strong congressional interest in uniform regulation of employee benefit plans" and acknowledged at a minimum that Congress did "declare its preference for federal regulation" by enacting ERISA section 514. Statement of NAIC on S.209 at 4.

Under ERISA, Congress left to the discretion of those who establish and/or administer employee plans the decision whether or not to provide health and welfare benefits "through the purchase of insurance," ERISA Section 3(1), 29 U.S.C. § 1002(1). The Commonwealth's mandated benefit statute drastically intrudes upon that discretion. "Because a plan that purchases insurance has no choice but to provide [the State mandated] benefits, the insurance provisions of § 47B effectively control the content of insured plans." (J.S. App. D, 20a). Plans will be forced either to self-insure or to provide—if they have the financial wherewithal and if the State laws are not conflicting—every benefit mandated by every State in which the plan participants work and by every State in which the plan participants reside.[4] For, mandated benefit statutes are nothing less than the back door through which States seek to enter a field that Congress

[4] Furthermore, if States have the power to add to the list of benefits that plans must provide, States would have the corresponding power to preclude plans from offering particular benefits. For example, the State might choose to limit participants' access to psychiatric social workers unless a medical doctor were in attendance, or preclude the use of chiropractic services. Such State interference with the freedom of plan design and the fiduciary judgment of trustees is contrary to the regulatory scheme intended by Congress. *See, Alessi, supra. Accord, UMWA Health & Retirement Funds v. Robinson,* 455 U.S. 562 (1982).

expressly prohibited from State intrusion. *See, e.g., Shaw, supra; Alessi, supra.*

Moreover, by being able to mandate benefits, States can mandate costs. Ceding to the States the power to mandate plan benefits and costs wrenches the whole realm of multiemployer plans from the context in which ERISA permits them to exist—that of collective bargaining. ERISA Section 3(37), 29 U.S.C. § 1002(37). And, where plans result "from collective bargaining, the additional federal interest in precluding state interference with labor-management negotiations calls for pre-emption of state efforts to regulate [plan] terms." *Alessi, supra*, 451 U.S. at 525.

Finally, it has long been recognized that the power to impose costs is the equivalent of the "power to destroy [and] that the power to destroy may defeat and render useless the power to create." *M'Culloch v. Maryland*, 14 U.S. (4 Wheat.) 431 (1819). Surely, the Congress did not intend that through the ERISA Section 514(b) insurance saving clause, the States would both eviscerate the preemption clause, as well as impose a stranglehold on the very plans, which the federal statute was designed to foster. *See*, ERISA Section 2(a), 29 U.S.C. § 1001(a).

The decision below creates cacophony, rather than harmony with the decisions of this Court and the express intent of ERISA and its founding fathers. Reversal of the decision below and affirmance of the interpretation of those who drafted ERISA allow the unfettered negotiation of benefit coverage without the interference of mandated benefit restraints. Plans would be free to retain the protection afforded by insurance and the vast majority of State regulation that works effectively in that area without State control over the structure, administration, and type of benefits provided by plans.

B. The argument of the Commonwealth and the reasoning of its high court conflict not only with one another, but also with decisions of this Court.

The Supreme Judicial Court of Massachusetts rejected the arguments asserted by the Commonwealth, but upheld the State statute. The State court concluded that "Section 47B affects only the substantive content of plans—a subject completely untouched by ERISA's regulatory provisions" (J.S. App. D, 22a)—and that consequently the State law cannot be in conflict with those provisions. The court then held that absent a conflict, the State statute withstood preemption. *Id.* This "conflict analysis" is merely another form of the theory that where a State law does not directly regulate plans but has only a collateral effect, the State law is not preempted.

Not only did this Court refuse to accept the "collateral effect theory" in *Alessi, supra*, 451 U.S. at 525, but it specifically rejected the "conflict analysis" in *Shaw, supra*, 51 U.S.L.W. at 4971. This Court has made it clear that in testing the scope of ERISA preemption, the relevant inquiry is not whether there is a conflict between federal and State law, but rather whether and to what extent the State laws "relate to" plans, ERISA Section 514(a), 29 U.S.C. § 1144(a). *See, Shaw, supra*, 51 U.S.L.W. at 4971-72. This Court acknowledges the importance that the Congress attaches to the need for uniform administration of interstate plans, free from the interference and chaos that would otherwise be part of every border crossing.

The *Shaw* decision should have completed the circle, closing any State manufactured loopholes in preemption, by merging judicial construction of ERISA with the interpretation of ERISA's drafters. As the sole dissenting Massachusetts Justice correctly recognized on remand, Section 47B must be preempted, because it is not a law

that "regulates insurance" within the meaning of ERISA's saving clause. (J.S. App. A, 8a).

However, in the majority opinion, the State court insisted again on utilizing the "conflict analysis" that was rejected in *Shaw*. The court reiterated that the State statute "makes no attempt to regulate employee benefit plans directly,"[5] but at the same time the court acknowledged that Section 47B "effectively controls the content of insured welfare benefit plans." (J.S. App. D, 20a). Thus, by its decision, the State court chose to undermine the uniform federal system of employee benefit plans, thereby placing the good of the Commonwealth ahead of the common good.

Perhaps because it recognizes that this Court rejected the "conflict analysis" upon which the lower court's decision rests, the Commonwealth has chosen to revive the argument it made below that where a State statute "applies to insurance and does not treat plans as insurers it is not preempted." (J.S. App. D, 21a). Yet, even the court below expressly rejected that argument. The State court was "wary of such a literal reading, which might permit the State, through its insurance laws, to . . . negate the unmistakable intent of Congress to work a

[5] The NCCMP asserts that there is nothing "indirect" about regulation of employee plans under the State statute. The Supreme Judicial Court takes the position that State regulation of the subject insurance policy is not direct regulation of plans. However, the Massachusetts Superior Court held that "the insurance policies involved here are employee benefit plans within the meaning of [ERISA Section 4(a)] and are not within the exceptions contained in [ERISA Section 4(b)]." (J.S. App. I, 74a). This holding of the superior court has not been challenged and is, thus, the law of the case. Since Section 47B is agreed by all to regulate these policies directly, and since these policies are held to be employee plans, than Section 47B directly regulates employee plans. Consequently, it defies logic that the State statute was not held below to be preempted.

broad preemption."[6] *Id.* Moreover, the Appellee's position stands in direct conflict with recent decisions of this Court.

In *Shaw*, this Court addressed the enforceability of a State disability insurance law with respect to employee plans covered by ERISA. 51 U.S.L.W. at 4973-74. The State statute in *Shaw* was on its face an "insurance law", *id.* at 4973, and it did not treat plans as insurers, *see*, ERISA Section 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B). Therefore, using the Appellee's approach, the statute in *Shaw* would have been enforceable against ERISA plans. However, this Court held the statute unenforceable, *Shaw*, *supra*, 51 U.S.L.W. at 4974.

So, too, in *Agsalud*, this Court was asked specifically to address the interaction between the HPHCA, a state law mandating benefits, and a nationally-based employee benefit plan that provided health benefits. *See*, *Agsalud*, *supra*, 633 F.2d at 763. The facts of the case reveal that the State statute required employers doing business in Hawaii to provide specific benefits, some of which the Standard Oil Company was not providing in its plan, *id.* There is no dispute that the HPHCA is an insurance law, and it does not deem employee plans to be insurers. *See*, *e.g.*, Statement of Sens. Inouye and Matsunaga on S. 209, presented to the Committee on Labor and Human Resources, United States Senate, Feb. 7, 1979. Thus, pursuant to the position of the Appellee Commonwealth, the Hawaii statute should have been enforceable against ERISA plans. However, this Court affirmed the decision of the Ninth Circuit Court of Appeals in *Agsalud*, holding that ERISA precluded the enforcement of the HPHCA as it relates to employee plans covered by

[6] This Court has expressed its disfavor, too, with the plain meaning rule of construction embraced by the Appellee. *Train v. Colorado Public Interest Research Group, Inc.*, 426 U.S. 1, 10 (1976) (quoting *United States v. American Trucking Ass'ns.*, 310 U.S. 534, 543-44 (1940)).

ERISA, 454 U.S. 801 (1981). *Accord, Hewlett-Packard Co. v. Barnes*, 571 F.2d 502 (9th Cir.), *cert. denied*, 439 U.S. 831 (1978). Nevertheless, the Appellee persists in seeking to advance State circumvention of ERISA's preemptive provisions by asserting that the ERISA Section 514(b) exception swallows the rule.

CONCLUSION

For the foregoing reasons, the NCCMP respectfully urges this Court to reverse the decision of the Supreme Judicial Court of Massachusetts in these cases.

Respectfully submitted,

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Nos. 84-325, 84-356.

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In the
Supreme Court of the United States.

OCTOBER TERM, 1984.

METROPOLITAN LIFE INSURANCE COMPANY,
APPELLANT,
v.
COMMONWEALTH OF MASSACHUSETTS,
APPELLEE.

THE TRAVELERS INSURANCE COMPANY,
APPELLANT,
v.
COMMONWEALTH OF MASSACHUSETTS,
APPELLEE.

ON APPEAL FROM THE SUPREME JUDICIAL COURT FOR THE COMMONWEALTH OF MASSACHUSETTS.

Brief Amicus Curiae of the International Brotherhood of Electrical Workers Local 421 Health & Welfare Fund, the Sheet Metal Workers Local 297 Health and Welfare Fund, and the New Hampshire Plumbers Health and Welfare Fund, in Support of Appellants.

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Question Presented.

Whether a state statute that requires insured employee benefit plans to provide specified minimum benefits for certain kinds of medical services is preempted by section 514(a) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1144(a).

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II. In construing ERISA § 514(b)((2)(A), this court should consider Congress' purposes in enacting ERISA which were, through minimizing the regulation of ERISA plans, to encourage their voluntary adoption. Plans such as *Amici's* whose members play a significant role in determining the content of the plans, illustrate the type of plans Congress wished to encourage 8

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Interest of Amici Curiae.

*Amici** the International Brotherhood of Electrical Workers (IBEW) Local 421 Health and Welfare Fund, the Sheet Metal

* Pursuant to Supreme Court Rule 36.2, *amici* appear with the consent of all parties. Copies of the letters granting consent have been filed with this brief.

Workers Local 297 Health and Welfare Fund, and the New Hampshire Plumbers Health and Welfare Fund are located in the State of New Hampshire. They, along with five other funds who share a common administrator provide benefits to approximately 13,449 participants and beneficiaries in the construction industry in New Hampshire, Maine and Vermont (A. 1-36, 37). The funds are employee welfare benefit plans within the meaning of Section 3(1) of ERISA, 29 U.S.C. § 1002(1) (A. 1-38) (hereinafter referred to as "ERISA plans"). Additionally, they are "Taft-Hartley trusts" within the meaning of the Labor Management Relations Act, 29 U.S.C. § 186(c) (A. 1-39). Each of the plans is insured by policies purchased by them and member benefits are paid by the insurance companies in the first instance. This brief is being filed in support of appellants Metropolitan Life Insurance Company and the Travelers Insurance Company. *Amici* have a strong interest in seeing laws such as section 47B of Massachusetts General Laws chapter 175, which mandate the benefits to be provided by insured ERISA plans, invalidated. Such laws frustrate the ability of such plans to provide the benefits requested by their members, and increase both the cost of the plans themselves and of their administration. *Amici* believe these results were not intended by Congress when it enacted ERISA, and that ERISA's goals are frustrated by the enforcement of mandated benefit laws against either companies providing insurance policies to ERISA plans or the plans themselves.

Summary of Argument.

Employee benefit plans such as those represented by *amici* were in existence long before Congress enacted ERISA, and Congress clearly had them in mind when it was considering the

provisions of ERISA. One of the important aspects of such plans is the extent to which plan administrators and the members themselves determine the benefits to be afforded under the plan. Congress made a deliberate choice to leave this aspect of employee benefit plans governed by ERISA untouched, not only by the regulating provisions of ERISA, but also by state regulations. In interpreting, not only ERISA's preemption clause, but also the clause "saving" state insurance regulation, this Court should give full effect to Congress' intent.

The court below, and other courts which have upheld state laws purporting to be "insurance regulation" that mandate the benefits to be included in employee benefit plans, erroneously considered only the language of the law at issue in holding that, because it says it applies to insurance policies, it does not "directly" regulate the plans to which policies are issued. *Amici* believe the proper analysis is to consider the actual impact of such laws, which significantly interfere with the design and administration of such plans, as the actual experience of *amici* and similar plans illustrates. *Amici* believe that Congress, in enacting the insurance "saving" clause, had in mind "traditional" insurance regulation which would have only an incidental effect on plans insured by an insurance policy.

Laws which mandate the benefits to be included in a health insurance policy issued to an ERISA plan do nothing to advance the goals of "traditional" insurance regulation, which is made necessary because of the existence of the insurance industry. Rather, mandated benefit laws are simply means for achieving certain general health and welfare goals, which would be thought desirable regardless of the existence of insurance. On the other hand, mandated benefit laws do much to frustrate Congress' goals in enacting ERISA. Most importantly, they discourage the voluntary adoption of employee benefit plans

by making them more expensive and less suited to the needs of their members, and they threaten the solvency of plans already in existence.

Argument.

I. Based Upon the Experience of *Amici* with New Hampshire Laws Similar to Massachusetts General Laws c. 175, § 47B, Such Laws are Enacted, at Least in Part, for the Purpose of Mandating the Terms and Conditions of ERISA Plans, Regardless of the Extent to Which a Plan Is Insured. As Such, Mandated Benefit Laws Are Not "Insurance Regulation" Within the Meaning of ERISA § 514(b)(2)(A), Because They Have a Direct Effect on ERISA Plans, While Having Only an Indirect Impact on Insurance.

Amici funds were parties to a previous action challenging a New Hampshire mandated health benefit law similar to § 47B of Massachusetts General Laws c. 175, at issue in this litigation. The action was eventually reported as *Wadsworth* v. *Whaland*, 562 F.2d 70 (1st Cir. 1977), *cert. denied*, 435 U.S. 980 (1978). This was a challenge to N.H. RSA 415:18-a, 419:5-a, and 420:5-a. Like the Massachusetts statute, this law mandates the inclusion of mental health care benefits in group medical insurance policies, including policies issued to ERISA plans. The First Circuit held that the New Hampshire law was not preempted by § 514(a) of ERISA, 29 U.S.C. § 1144(a), to the extent that it applied to insurance policies issued to an ERISA plan. The court's holding turned on interpretations of § 514(b)(2)(A) of ERISA, 29 U.S.C. § 1144(b)(2)(A), which saves state laws regulating insurance from preemption (the

"savings clause") and § 514(b)(2)(B) of ERISA, 29 U.S.C. § 1144(b)(2)(B), the so-called "deemer clause," which provides that a state may not deem an employee benefit plan to be an insurance company, insurer, or in the business of insurance for the purposes of its insurance laws. In the first instance, the First Circuit held that the New Hampshire mandated benefit law at issue "is . . . a state law regulating insurance," 562 F.2d at 77, for purposes of the savings clause, and secondly, that it only indirectly affected the ERISA plans involved, so that the "deemer clause," which "does not prohibit a state from indirectly affecting plans by regulating the contents of group insurance policies purchased by the plans," *id.* at 78, did not apply.

The opinion of the Massachusetts Supreme Judicial Court in this case reflects a similar analysis: "the statute as we consider it makes no attempt to regulate employee benefit plans directly." *Attorney General* v. *Travelers Insurance Co.*, 391 Mass. 730, 735 (1984). In both instances the conclusion was reached that mandated benefit laws only indirectly affect ERISA plans without any analysis of how the distinction between a "direct" and "indirect" effect should be determined; the assumption seems to be that only the language, and not the actual impact of a law should be considered. As will be discussed in greater detail, *infra*, *amici* believe mandated benefit laws are preempted, and not subject to the "savings clause," because, unlike "traditional"[1] insurance regulation, they directly affect and interfere with employee benefit plans, while having much less of an impact on the insurance companies which issue policies to the plans. Furthermore, in determining whether a state law "regulates insurance" within the meaning of the savings clause, and whether it falls within the prohibition of the deemer clause,

[1] Throughout this brief, when the phrase "traditional insurance regulation" is used, it refers to the same phrase as used and defined by appellant Metropolitan in its brief.

amici suggest that the only approach which would give full effect to Congress' intention is to look at the *actual* impact of the law, rather than its *purported* effect. This is the approach suggested by Justice Wilkins, who dissented below. As he pointed out, "General Laws c. 175, § 47B, is not a law 'which regulates insurance' within the meaning of ERISA § 514(b)(2)(A). As applied to employers, § 47B concerns health benefits that an employer must provide, . . . and as to employee benefits § 47B only incidentally regulates insurance." 391 Mass. 736.

Since the decision in *Wadsworth,* the State of New Hampshire has taken additional steps to try to regulate employee benefit plans covered by ERISA. In 1981 the State Legislature enacted Chapter 391 of the Laws of 1981, codified at N.H. RSA 415:18 VII(g), which required a 39-week extension of benefits to any beneficiary of a group health and accident plan who became ineligible as a result of the termination of the plan, for whatever reason. Unlike Massachusetts, which has disavowed any intention to enforce its law against self-insured plans, 391 Mass. at 730-731 n.2, the New Hampshire Legislature and Insurance Department applied the law "to all group health policies or contracts . . . and . . . all self-funded or self-insured employee health benefit plans." *Dawson* v. *Whaland,* 529 F.Supp. 626, 630 n.10 (D.N.H. 1982). This attempt was struck down by the District Court for the District of New Hampshire.

That court additionally held that, because the insurance policies issued to the funds involved in that case were, in all cases, "experience-rated," and in most cases "stop-loss" policies, *id.* at 628, the "Funds fall within the definition of 'self-funded or self-insured employee health benefit plans'." *Id.* at 630. *See also Wadsworth* v. *Whaland* at 75, citing *General Electric Co.* v. *Gilbert,* 429 U.S. 125, 129 n.3 (1976) (funds whose policies are experience-rated are, "for all practical purposes . . . self-insurer[s]"); *General Split Corp.* v. *Mitchell,*

523 F.Supp. 427 (E.D. Wis. 1981) (application of state insurance regulations to funds insured by stop-loss policies is preempted).

Since the decision in *Dawson* v. *Whaland* and the *dicta* in *Wadsworth* suggesting that funds such as *amici* could properly characterize themselves as "self-insured" and thus avoid state insurance regulations, the New Hampshire Insurance Department has tried once again. Presently, New Hampshire Insurance Rule 401.01(e)(3) purports to require all stop-loss or excess insurance policies issued "to any employer with a self-funded employee benefit plan" to comply with both the mandated mental health care benefit law, N.H. RSA 415:18-a, and the 39-week extension law, N.H. RSA 415:18, VII, IX, X and XI.[2] While this illustrates the persistent and blatant attempts by at least one state to regulate the terms and conditions

[2] New Hampshire Insurance Rule 401.01(e)(3) provides in full:

(3) Additional standards applicable to group excess or group stop-loss policies.

a. No insurer may issue a policy generally described as a group excess or group stop-loss policy to any employer with a self-funded employee benefit plan which plan provides benefits for medical or hospital expenses but which does not provide benefits for nervous and mental conditions that either equal or exceed the required benefit standards imposed upon a group or blanket accident and health insurance policy by RSA 415:18-a.

b. Any insurer providing what is generally described as group excess insurance or group stop-loss insurance under a policy issued to any employer with a self-funded employee benefit plan which plan provides hospital or surgical expense insurance or major medical expense insurance must provide to either the employer's employees or to the dependents of any employee of the employer or to both such employees and dependents whose insurance under the employer's employee benefit plan terminates for any reason a conversion privilege that is identical to or more favorable than the conversion privilege required under a conventional group accident and health insurance policy by the New Hampshire insurance code and specifically by RSA 415:18, VII, IX, X, and XI.

of ERISA-covered employee benefit plans, and the consequent need for this Court to intervene and clarify the scope of ERISA's preemption, *amici* do not wish to suggest that this Court's decision should turn on whether a plan is technically self-insured or not. Rather, *amici* urge the Court to focus on the impact that mandated benefit laws such as those in force in Massachusetts and New Hampshire have on an employee benefit plan, as opposed to the insurance company issuing a policy to the plan; the impact is the same whether the plan is fully self-insured, partially insured, or fully insured.

II. In Construing ERISA § 514(b)(2)(A), This Court Should Consider Congress' Purposes in Enacting ERISA Which Were, Through Minimizing the Regulation of ERISA Plans, to Encourage Their Voluntary Adoption. Plans Such as *Amici*'s, Whose Members Play a Significant Role in Determining the Content of the Plans, Illustrate the Type of Plans Congress Wished to Encourage.

The administrator of *amici's* plans, Mr. James Dawson, testified at length in the trial of this case (A. 1-29, 1-98). His experience in administering employee benefit plans dates back to 1953 (Tr. 1-30) when the first plan was established through the collective bargaining process. As he described, the union members have a great deal to say about the type of benefits to be included in their plan:

> I go to the union meetings, and we . . . suggest to them the various types of coverages that are available to us. Some coverages they turn thumbs down on absolutely. They are not interested at all . . . You can have a man stand up and say . . . 'I certainly feel we've got to provide

> dental coverage.' Another young fellow, particularly, will get up and say, 'Lookit, I think maternity benefits are an absolute must' . . . Somebody else will say, 'Lookit, I've got a child here that can't even get passing grades in school because she needs a pair of glasses . . . and I can't afford [them]' . .'. [M]embers . . . vocalize very vehemently about what they personally feel is needed . . . After the discussions are all over, the union actually takes a vote, and the predominant view [as to which benefits to seek] prevails.

(A. 1-43). Mr. Dawson described the process at the subsequent collective bargaining agreement negotiations as follows:

> [W]e discuss with the employer what we want. We might tell them we want surgical benefits, hospitalization, life insurance, weekly income protection, vision, dental, . . . Obviously you don't get everything you ask for . . . [I]t's actually a tradeoff between what they want and what the employers are willing to give them . . . [A]fter hard negotiations they wind up with a minimal package and hope that the next time around they'll add a few more benefits.

(A. 1-40, 1-41). As noted, at least some of the plans administered by Mr. Dawson predate ERISA. Congress doubtless had such plans in mind when it enacted ERISA and omitted from its provisions any attempt to dictate the contents of ERISA plans.

Congress recognized, when it passed ERISA, the importance to the national economy of encouraging voluntary employee benefit plans. Similarly, Mr. Dawson testified to the importance of such plans to the individual workers:

> I would say that in the last few years [health benefits play] . . . one of the dominant roles [in the negotiations between employer and employees] . . . because health care costs have escalated so tremendously, far more than any other segment of our economy . . . Therefore, the members are aware of these extreme costs. It's my personal feeling that a person can't afford not to have insurance in this day and age . . . [M]ost of the members feel that way about it . . . I've seen negotiations where no other benefit was discussed other than health care or pensions.

(A. 1-41).

In furtherance of its recognition of the importance of employee benefit plans, and in order to encourage their voluntary adoption, Congress made a deliberate choice to impose upon them the least regulation necessary.

> [A]ll of the provisions in the Act have been analyzed on the basis of their projected costs in relation to the anticipated benefit to the employee participant . . . The [House] Committee [on Education and Labor] believes that the legislative approach of establishing minimum standards and safeguards for private pensions is not only consistent with the retention of the freedom of decision making vital to pension plans, but in furtherance of the growth and development of the private pension system . . . The Bill reported by the Committee represents an effort to strike an appropriate balance between the interests of employers and labor organizations in maintaining flexibility in the design and operation of their pension programs, and the need of the workers for a level of protection which will adequately protect their rights and just expectations.

H.R. Rep. No. 533, 93 Cong., 2d Sess., reprinted in 1974 US Code Cong. & Ad News 4639-40, 4647. As noted by the United States District Court for the Eastern District of Michigan in *Michigan United Food & Commercial Workers Union* v. *Baerwaldt*, 572 F.Supp. 943 (E.D. Mich. 1983), appeal docketed, No. 83-1570 (6th Cir. 8/16/83):

> this nurturant attitude towards private plans must be carefully considered in determining the preemption issue . . . By generally disallowing state regulations that might enhance protections for employees within any particular state, Congress was making a judgment that the greater national good called for both a minimum and maximum on the regulation of employee benefit plans.

Id. at 949-950.

The court in *Baerwaldt* held that, in furtherance of this Congressional purpose, a Michigan law mandating benefits for substance abuse treatment in insurance policies issued to, *inter alia*, ERISA plans, was preempted. In so holding, the court adopted an approach similar to that suggested by *amici*, and, rather than looking only at what the law *purported* to do (regulate insurance), considered also the actual *effect* of the law on ERISA-covered employee benefit plans.

> I do not think that [the "savings"] clause was aimed at preserving state statutes which more than tangentially affect employee benefit plans . . . I find that its purpose was to avoid unintended and wholesale preemption of important fields of state concern by making clear that statutes only incidentally affecting employee benefit plans, but not regulating their terms and conditions, were not to be ousted . . . I would confine the term 'regulates

> insurance' so as to exclude laws which do not so much monitor the insurance industry as its customers from the clause's protection.

Id. at 948, 951. *See also Metropolitan Life Ins. Co.* v. *Insurance Com'r,* 51 Md. App. 122 (1982), *rev'd, Ins. Com'r. of State* v. *Metropolitan Life Ins.*, 296 Md. 334 (1983). (Invalidating, as preempted by ERISA, Maryland law requiring benefits for psychotherapy services.)

III. The Impact of the New Hampshire Mandated Benefit Law on *Amici* and Other Employee Benefit Plans has been Direct and Significant. It Has Required Them to Remove Benefits Desired by the Members, Increased Costs and Employee Hostility, and Threatened the Solvency of Some Plans. By Having This Impact Mandated Benefit Laws Frustrate Congress' Goals in Enacting ERISA.

As the Maryland appellate court in *Metropolitan Life* and the Eastern District of Michigan in *Baerwaldt* recognized, mandated benefit statutes impact directly and adversely on employee benefit plans, as opposed to the insurance industry, and should not therefore be considered "insurance regulation" within Congress' intent. In his trial testimony, Mr. Dawson, the administrator of *amici* plans, described the magnitude of the impact:

> In the case of the Northern New England Carpenters, [they] . . . felt they could not afford to pay for the benefits required by that statute and still keep all the benefits they had in their own particular plan. The net result was that

> they increased their eligibility requirements . . . and they eliminated all vision and dental care . . . . Basically, it had the same impact on most of the other plans . . . [B]esides a cost, it had an antagonistic result . . . The members became antagonistic to me as well as the very fact that they had to have something they didn't want and to give up something they did want . . . [T]he Bricklayers Fund went to a position where they were technically financially insolvent . . . [T]hey . . . asked the employers . . . to take . . . an additional contribution out of their pay envelope . . . and put that money into the fund to keep it solvent.

(A. 1-55, 1-60). As Mr. Dawson's testimony illustrates, the cost of additional mandated benefits is absorbed directly by the plans, with a minimal corresponding effect on the insurance companies which insure the plans, since they are able to simply pass on to the funds the additional costs in the form of premium increases. Thus, the effect of mandated benefit statutes such as Massachusetts' and New Hampshire's clearly frustrates Congress' intent to permit the plans themselves to make the decisions as to the scope and terms of coverage. As this Court noted in *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981), "ERISA leaves this question [of the content of an employee benefit] largely to the private parties creating the plan . . . [T]he private parties, not the Government, control the level of benefits." *Id.* at 509.

In addition to the cost of the additional benefits themselves, Mr. Dawson testified regarding the administrative burdens and costs imposed upon employee benefit plans by mandated benefit laws with respect to plans covering employees in more than one state:

> [I]f John Smith is contributing 73 cents an hour and John Brown is contributing 73 cents an hour and one of them lives in Maine and one lives in New Hampshire, . . . they are both contributing to the same plan . . . yet one has a coverage that the other one doesn't . . . [E]ven worse than that, . . . because the man living in Maine didn't have to have the New Hampshire benefits, he could have greater benefits in another area to compensate for it, you would have actual chaos there . . . [I]t causes tremendous resentment and real hardship.
>
> . . .
>
> ERISA requires . . . a plan description to be delivered to every participant . . .[W]e would have to produce a plan document for each particular state and what benefits that particular state had . . . [T]he trustees . . . felt that the cost impact of . . . providing separate booklets for everybody . . . would be greater than actually providing the uniform benefits for everybody . . . [T]hey spent the extra money to provide the same benefits for everyone regardless of where they lived or worked.
>
> . . .
>
> [I]t goes to the very basics of creating these plans. Plans such as the Carpenters' were created in order that you might have uniform benefits for people who have to work in three different states . . . [I]f you're going to create havoc, in my opinion, by having different mandated benefits in all three states, you are going to increase tremendously the administrative costs.

(A. 1-62, 1-66). This, again, is a concern that was at the heart of Congress' purpose in enacting ERISA. In *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 103 S.Ct. 2890 (1983), this Court considered that concern at some length, and "Congress'

goal of ensuring that employers would not face 'conflicting or inconsistent state and local regulation of employee benefit plans." 103 S.Ct. at 2904. This Court concluded that Congress' concerns lay at the heart of the preemption clause. "By establishing benefit plan regulation 'as exclusively a federal concern' [cite omitted] . . . Congress minimized the need for interstate employers to administer their plans differently in each State in which they have employees." *Id.* at 2904. Just as this Court construed the ERISA provisions at issue in *Shaw* in light of Congress' purpose to minimize conflicting state regulations so should it construe the insurance "savings" clause.

IV. Section 514(b)(2)(A) of ERISA, the "Savings Clause", Should Not Be Held to Apply to Mandated Benefit Laws, Which, Although Nominally "Insurance Regulation," Impact Directly and Adversely on ERISA Plans, as Opposed to Their Insurers, Which Have No Necessary Relationship to the Insurance Industry, and Which Serve None of the Goals of Traditional Insurance Regulation.

The Court below distinguished *Shaw* on the ground that it did not address ERISA § 514(b)(2)(A), the "savings clause." If the savings clause were not at issue, however, *Shaw* and *Alessi* would be squarely applicable to the instant case; both invalidated State laws which had the effect of dictating the terms and conditions of employee benefit plans. However, as appellant Metropolitan points out in its brief, a State could easily avoid the results in those cases by couching its legislation in terms of "insurance regulation," assuming the reasoning of the Court below is correct. Under that rationale, New Jersey would be free to prohibit workers' compensation set off provi-

sions in insurance policies issued to employee benefit plans. Similarly, New York could forbid disparate treatment of pregnancy benefits in such insurance policies. This is essentially what Massachusetts has done. Had not Massachusetts included the language in § 47B relative to insurance policies, but simply required the inclusion of mental health benefits in employee benefit plans, *Alessi* and *Shaw* would control, and it is clear the statute would be preempted with respect to ERISA-covered plans. If preemption were not an issue, there would in fact be no need to include the reference to insurance policies. Regardless of whether the law is written to apply directly to the plan, or through an insurance policy, however, the impact on employee benefit plans would be the same.

This is not the case with legislation which appellants refer to as "traditional" insurance regulation. For example, *American Progressive Life and Health Insurance Company* v. *Corcoran*, 715 F.2d 784 (2d Cir. 1983) upheld regulations establishing maximum commission rates for insurance salesmen. As the Court noted, the impact of those regulations fell squarely upon "the internal business practices of the [insurance] Company," *id.* at 787, as opposed to the plans the company insured. In the absence of the insurance industry, there would be no purpose for such regulations; the same cannot be said of mandated benefit statutes.

In *Bell* v. *Employee Security Benefit Association*, 437 F.Supp. 382 (D. Kansas 1977) (which held that defendant plan was not an employee benefit plan within the meaning of ERISA, and thus not exempt from State insurance regulation), the Court listed what it believed are "the primary purposes of insurance regulation": "first, to avoid overreaching by insurers; second, to assure solidity and solvency of insurers; third, to assure that rating classifications and rates are reasonable and fair." *Id.* at 391. While these purposes are served by "traditional" insurance regulation, it can hardly be said that they are

served by mandated benefit laws. Rather, it is apparent that the primary purpose of such laws is to promote the health and welfare of the citizens of a state by encouraging the use of certain types of health care (or, in the case of an anti-set-off law such as that in issue in *Alessi*, by increasing the income available to an injured person). The only reason for couching such laws as "insurance regulation" is to limit their applicability (presumably for political reasons) to persons who have already demonstrated a need and a willingness to pay for them. It could be argued that such laws fall within the purpose of preventing "overreaching" by insurance companies in the typical insurer-insured relationship. Such an insured might not otherwise have the bargaining power to require the inclusion in his or her health insurance policy of certain benefits at a reasonable cost, or the sophistication to foresee a need for their inclusion. This analysis, however, does not apply to an employee benefit plan of the type represented by *amici*. As the *Bell* Court points out, "there is no threat of overreaching when the given plan is provided on a non-profit basis. Any unfairness by the employer . . . would probably result in labor problems." *Id.* at 391. Certainly employee groups such as those represented by *amici* enjoy much greater bargaining power vis-a-vis insurance companies than a single policyholder, or an unorganized group of employees (such as those involved in *Bell*). Finally, while a state may argue that its inability to require employee benefit plans to purchase certain benefits increases premium costs for other policyholders, that is a result already sanctioned by Congress when it exempted employee benefit plans from state insurance regulation.

This is because employee benefit plans such as those represented by *amici* can at any time choose to become self-insured, which appellee concedes would free them of the impact of mandated benefit laws. That Congress could not have intended such an absurd result seems evident. On the one hand,

forcing employee benefits plans to become self-insured does nothing to further the goals of state insurance regulations. If anything, it would tend to increase insurance premiums in general, by drastically reducing the number of persons among whom a particular risk is spread. On the other hand, it would do much to frustrate Congress' intent to foster the growth and solvency of employee benefit plans. As Mr. Dawson testified, there is a very real risk that some plans would be unable to continue in existence if they were forced to become uninsured.

> Many of them are small plans that cannot afford to go uninsured . . . It's a Catch 22 situation. They can't afford the benefits, and they can't afford to avoid them by going uninsured . . . If they try to go uninsured, I think many of them will collapse.

(A. 1-66, 1-67, 1-68). In addition to the financial protection that insurance provides, Mr. Dawson spoke of other benefits afforded by purchasing insurance policies, which would be eliminated if the plans were forced to become self-insurers.

> The advantages of an insured plan . . . are the great stability and the experience and the knowledge and the know-how that any insurance company brings to the plan . . . As a third-party payer they are not subject to the political pressures that would be evident if, for instance, my office was personally paying the claims . . . [U]nion members, trustees, and so forth, could . . . put pressure on me and my employees to pay claims that normally should [not] [*sic*] have been paid.

(A. 1-49). That Congress recognized these benefits and contemplated the purchase of insurance is evident, not only in Section 3(1) of ERISA, 29 U.S.C. § 1002(1) which includes insured plans within the definition of plans covered by ERISA, but also in the recently-enacted Multiple Employer Trust (METS) amendments,[3] 29 U.S.C. § 1144(6)(A), which subject non-collectively-bargained uninsured employee benefit plans to more extensive state regulation than insured plans.

Conclusion.

In conclusion, *amici* respectfully urge this Court to hold that state laws which have the effect of mandating the benefits to be included in an employee welfare plan are preempted by Section 514(a) of ERISA, whether they are directed to insurance policies insuring such plans, or phrased more broadly. *Amici* urge this Court to narrowly construe Section 514(b)(2)(A) the "savings clause," to include only "traditional" state insur-

---

[3] Enacted in 1983, § 1144(6)(A) of ERISA provides, in part:

> Notwithstanding any other provision of this section —
>
> (i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured . . . any law of any State which regulates insurance may apply to such arrangement to the extent that such laws provides
>
> (I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions . . . and
>
> (II) provisions to enforce such standards, and
>
> (ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, . . . any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this subchapter . . .

ance regulation, that is, regulation which has a direct impact only on the insurance industry and not, as here, customers who happen to be ERISA plans. Since mandated benefit laws such as § 47B and N.H. RSA 415:18-a, 419:5-a, and 420:5-a do not fall within that category and instead have a direct, adverse effect on the plans maintained by *amici* and similar plans, they should be struck down. The judgment of the Supreme Judicial Court of Massachusetts in this case should be reversed.

Respectfully submitted,

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IN THE

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October Term, 1984

METROPOLITAN LIFE INSURANCE COMPANY,
Appellant

v.

COMMONWEALTH OF MASSACHUSETTS
Appellee

ON APPEAL FROM THE SUPREME JUDICIAL COURT
FOR THE COMMONWEALTH OF MASSACHUSETTS

BRIEF *AMICUS CURIAE* OF THE AMERICAN CHIROPRACTIC ASSOCIATION IN SUPPORT OF THE APPELLEE

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QUESTION PRESENTED

Whether, *as a threshold question,* the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1101 *et seq.* (ERISA) unconstitutionally preempts a Massachusetts statute which mandates inclusion of minimum mental health care benefits in all health and accident insurance policies covering the State's residents.

The narrow constitutional issue here is whether the Ninth and Tenth Amendments are limitations on Congress' powers under the Commerce Clause with respect to a preemption clause in a Federal statute which in other respects may be within Congress's constitutional power to regulate interstate commerce in insurance.

Because "the Constitutionality of an Act of Congress is drawn in question ...", 24 U.S.C. §2403(a) may be applicable.

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No. 84-325

IN THE

Supreme Court of the United States

October Term, 1984

METROPOLITAN LIFE INSURANCE COMPANY,
Appellant,

v.

COMMONWEALTH OF MASSACHUSETTS,
Appellee

On Appeal from the Supreme Judicial Court
for the Commonwealth of Massachusetts

BRIEF *AMICUS CURIAE* OF THE American Chiropractic Association

---

This case presents a fundamental question involving the constitutional structure of the American Republic:

-whether Constitutional Federalism, through shared and concurrent Federal and State power, is protected as a means of coping with an urgent social and economic crisis for State and local governments and their residents, or

-whether, in the absence of any showing of supervening national necessity or emergency, a centralist government which forbids States to experiment with various solutions to this crisis can supercede Constitutional Federalism.

INTEREST OF AMICUS

The American Chiropractic Association is the largest professional chiropractic association in the United States, with members in all 50 states who are licensed as chiropractors by their respective States. Chiropractic is a licensed health profession in all 50 States.

Chiropractors are defined by Congress as "physicians" authorized to provide health care in Medicare, Medicaid, the Federal Employees Compensation Act, the Federal Longshoremen's and Harborworkers' compensation program, and the cooperative Federal/State Vocational Rehabilitation program. The U.S. Department of Education has officially recognized a chiropractic agency to accredit chiropractic colleges.

Chiropractic health care is also a benefit in many private commercial health insurance programs and labor-management health programs. At least 35 States have enacted statutes which require inclusion of chiropractic health care in all commercial health insurance applicable to their local citizens and residents. See Brief *Amicus* of Health Insurance Association of America, Appendices IIB and III.

If ERISA may constitutionally preempt this State's mandatory mental health benefits, presumably the same rule would apply to the 35 States which mandate chiropractic health care, a result which would be a serious detriment to the multiple thousands of *Amicus'* members and to their millions of patients. *Amicus* has a major interest in the outcome of this case, as do the patients of its members whose health would be jeopardized by such Federal preemption.

SUMMARY OF ARGUMENT

This Court is faced with a critical and unresolved threshold problem of Constitutional Federalism. This Court has never decided the threshold question whether ERISA's preemption provision is an unconstitutional abridgement of the rights reserved to the States under the Tenth Amendment and of the rights retained by the American people under the Ninth and Tenth Amendments. All prior cases in this Court and in the lower courts dealing with ERISA's preemption were decided solely on grounds of statutory construction. The threshold constitutional question has not been raised by the parties and was not briefed and argued to the Court in those prior cases. This threshold issue must be settled first.

The Tenth Amendment is an independent constitutional restriction on Congress' power under the Commerce Clause. It is the fundamental protection of the Bill of Rights for Constitutional Federalism which guards the American people against a would-be all-powerful centralized government.

Amicus does not question Congress' power to regulate insurance under the Commerce Clause, but respectfully submits that *with respect to the very narrow issue of preemption*, Congress' powers under the Commerce Clause are limited by the Ninth and Tenth Amendments. On the record before the Court, the preemption provision is an unconstitutional and impermissible abridgement of Constitutional Federalism.

Since there is a total absence of any record showing of a national emergency of crisis, in carrying out its obligation of balancing independent and conflicting constitutional provisions the Court should affirm the

decision below not on the ground of statutory interpretation but on the basis that, with the record before it, ERISA's preemption is unconstitutional under the NINTH and TENTH Amendments.

ARGUMENT

THRESHOLD ISSUE: TENTH AMENDMENT'S PRESERVATION OF CONSTITUTIONAL FEDERALISM HAS BEEN COMPLETELY IGNORED BY BRIEFS AND COURT BELOW

The parties and the court below erroneously treated this case solely as one of statutory interpretation, thereby ignoring the fundamental threshold issue whether the Ninth and Tenth Amendments bar ERISA's preemption provision. That threshold question must be settled "before going further."[1]

This Court has not heretofore been squarely presented with the question of constitutionality of ERISA's preemption clause under the Tenth Amendment. In *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981) and *Shaw v. Delta Air Lines, Inc.*, 103 S. Ct. 2890 (1983), as well as in *Wadsworth v. Whaland*, 562 F.2d 70 (1977), *cert. den.* 435 U.S. 980, there was absolutely no discussion of the Tenth Amendment in the Briefs, or by the Court. The decisions went off on statutory interpretation, except for an occasional passing reference to the Supremacy Clause.

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[1]Wilson v. New, 243 U.S. 332, 334 (1917). See United States v. California State Water Resources, 694 F.2d 1171, 1175 (9th Cir. 1982).

In *Hopkins Federal S. & L. Ass'n. v. Cleary*, 296 U.S. 315 (1935), Cardozo said for the Court:

> "...nowhere here in the record did the defendant invoke the Tenth Amendment. We cannot accept it as determining the constitutional rights ... least of all when it appears that constitutional rights and privileges were not involved or argued" (at 432-3)[2]

Therefore, the rulings in such prior cases are not dispositive of the threshold question of constitutionality under a constitutional system of governence by limited authority, "...no more power than was absolutely necessary for an efficient central government."[3]

A major social and economic crisis now facing the American people is the capacity of local and state governments to assure their people, *in their local communities*, of adequate comprehensive health care at a reasonable and affordable cost. The extraordinary genius of the Constitution and the Bill of Rights is adaptability to the problems of successive generations of Americans. The appellee, in common with virtually all of the States, is experimenting with solutions to this peoples' crisis in health care arrangements. Federal preemption would foreclose such flexibility in the Federal system.

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[2]In oral argument before the Court in Oklahoma v. Woodring, 309 U.S. 623 mem. (1940), neither the parties nor the Court even mentioned the Tenth Amendment. Transcript of Proceedings, Jan. 29, 1940, vol. 1 and 2.

[3]Former Solicitor General Wade H. McCree, Jr., Civil Liberties and Limited Government, 64 NATIONAL FORUM 39 (Fall 1984).

Throughout our national history, Constitutional Federalism has been the energizing engine for State experimentation, sanctioned by concurrent exercise of Federal and State power. Justice Connor well described this historical role of the States as laboratories for developing new social, economic and political ideas.[4] This same pattern was followed by the Congress in the 98th Congress, by providing for cost-containment of hospitalization, through adopting a mechanism developed in New Jersey.[5]

By limiting consideration solely to statutory construction, the parties as well as the Court below have missed the threshold issue of the Tenth Amendment's role in preserving Constitutional Federalism. The instant case is classic on this constitutional issue. This Court must face the issue at the outset.

ERISA'S PREEMPTION PROVISION IS UNCONSTITUTIONAL UNDER TENTH AMENDMENT

Under the Tenth Amendment, the Federal Government may not constitutionally preempt the Massachusetts statute here involved.

This Court has held that under the Tenth Amendment "powers not granted are prohibited." *United States v. Butler*, 297 U.S. 1,68 (1936). See also *The Collector v. Day*, 78 U.S. 113 (11 Wall.) 124 (1870). Madison, the sponsor of the Tenth Amendment in 1791, said: "If the power was not granted, Congress may not exercise it."[6] George Washington wrote to

[4]Dissenting. Federal Energy Regulatory Commission v. Mississippi, 456 U.S. 743, 788-9 (1982) and her copious citation of cases and authority.

[5]P.L. 98-21, Sec. 601-607 (1983); 1983 C.Q. Almanac, 391 at 393.

[6]II Annals of Congress, 1857 (1791).

Lafayette that "...the people evidently retained everything which they did not in express terms give up."[7]

The grant of power to Congress by the Constitution was also a limitation of power.[8]

This doctrine has been recognized from the earliest days. In *McCulloch v. Maryland*, 17 U.S. 316 (4 Wheat. 579) (1819), Chief Justice Marshall stated the following prophetic words:

> "This government is ... one of enumerated powers. But the question respecting the extent of the powers actually granted is perpetually arising, and will probably continue to arise, as long as our system shall exist." (at 405).

Amicus raises the question of the Tenth Amendment's limitation on the Commerce Clause. The Commerce Clause does not specifically vest exclusive power in the Federal Government. Chief Justice Burger ruled that the same was true of the Copyright Clause.[9] The Founders knew how to provide exclusive jurisdiction when they intended to do so.[10]

[7]29 THE WRITINGS OF GEO. WASHINGTON 478 (Fitzpatrick ed. 1939).

[8]See Graham v. John Deere Co., 383 U.S. 1, 5-6 (1966). ("The [patent] clause is both a grant of power and a limitation.")

[9]Goldstein v. California, 412 U.S. 546, 553 (1973).

[10]The House has "sole power of impeachment," ART. I, Sec. 2, but the Senate has "sole power to try all impeachment," ART I, Sec. 3, "All Bills raising Revenue shall originate in the House of Representatives," ART. I, Sec. 7. Congress shall have exclusive jursidiction over the District of Columbia, Art. I, Sec. 8.

It is established doctrine enunciated by Chief Justice Taney, that legislation beyond the authority of the Congress under the Ninth and Tenth Amendments does not come within the protection of the Supremacy Clause.[11]

Amicus raises no question as to Congress' constitutional power to regulate insurance. But because of the Tenth Amendment such right does not include Federal preemption of State statutes mandating specific health services in health and accident policies covering their residents. "The existence of a permissible purpose cannot sustain an action that has an impermissible effect."[12] The permissible purpose here is regulation of insurance, the impermissible effect is Federal preemption in the circumstances of this record.

ERISA's preemption provision conflicts with the Tenth Amendment and cannot negate the operation of the Massachusetts statute.[13]

TENTH AMENDMENT IS AN INDEPENDENT LIMITATION ON CONGRESS' POWERS

In *Kansas v. Colorado,* 206 U.S. 46, 90-1 (1907) the Court said:

> "This Article X is not to be shorn of its meaning by any narrow or technical construction, but is to be considered fairly and liberally so as to give effect to its scope and meaning ...",

[11]Gordon v. United States, 117 U.S. 697, 705 (1864).

[12]Wright v. Council of the City of Emporia, 407 U.S. 451, 462 (1972).

[13]See Marbury v. Madison, 1 Cranch 137 (1803): Mississippi University for Women v. Hogan, 458 U.S. 718 (1982).

which the Court stated to be a limitation on an "attempt to exercise power which had not been granted." The Court stated that the Tenth Amendment was an "express limitation on the powers of Congress."

Hopkins Federal S. and L. Assn. v. Cleary, supra at 335-6, held an Act of Congress "unconstitutional encroachment upon the reserved powers of the States. United States Constitution Art. X":

> "The power of the Congress in the premises...being not exclusive, but at most concurrent...we are constrained to the holding that there has been an illegitimate encroachment by the government of the Nation upon a domain of activity set apart by the Constitution as the province of the states...(at 338)[14]

It is especially significant in this connection that in a brief for the United States (at pp. 59-60), Solicitor General Robert H. Jackson (later, Justice of this Court) in *United States v. Bekins,* 304 U.S. 27 (1938), advised this Court that its opinion in *Hopkins*

> "appears to view this conclusion as based upon the Tenth Amendment, independently of the scope of powers granted to the United States (pp. 335, 336).

This same conclusion, Jackson said, was buttressed by five other decisions of this Court.[15]

[14]U.S. v. Darby, 312 U.S. 100, 122-4 (1941) is dicta and is not dispositive since the Court's opinion specifically states that it was deciding the case only on the basis of the Fifth Amendment and purely as a matter of statutory construction (112).

[15]U.S. v. Butler, 297 U.S. 1, 68 (1936); Ashton v. Cameron County Water District, No. One, 298 U.S. 513, 527, 331 (1936); Steward Machine Co. v. Davis 301 U.S. 548 (1937); Helvering v. Davis, 301 U.S. 619 (1937); Cincinnati Soap Co. v. United States, 301 U.S. 308 (1937).

Another long line of cases is to the same effect, that the Tenth Amendment is an independent, affirmative limitation on the Congress, including actions based on the Commerce Clause.[16]

Still another line of cases also leads to the same conclusion. The Constitution is "...one instrument, all of whose provisions are to be deemed of equal validity."[17] Therefore, the Tenth Amendment must be applied "with equal validity" to the Commerce Clause.[18]

Even the most precise Constitutional authorizations to Congress, such as the bankruptcy power, are subject to the Bill of Rights. This Court ruled that "the bankruptcy power, like the other great substantive

[16]Standard Oil Co. of California v. Agsalud, 442 F. Supp. 695, 710 ("The Tenth Amendment imposes substantial limitations on Congress' power under the Commerce Clause"), *aff'd.* 633 F. 2d 760 (9th Cir. 1980), *aff'd. without opinion*, 454 U.S. 801 (1981); Gold Cross Ambulance v. City of Kansas City, 538 F. Supp. 956 (W.D. Mo., W.D., 1982), *aff'd.* 705 F.2d 1005 (8th Cir. 1983); Brown v. Brannon, 399 F. Supp. 133, 147 *et. seq* (M.D. No. Car., Durham Div., 1975), aff'd *without opinion* 535 F.2d 1249 (4th Cir. 1976); EEOC v. Ferris State College, 493 F. Supp. 707, 712 (W.D. Mich. SD, 1980); Marshall v. Del. River and Bay Authority, 471 F. Supp. 886, 891 (D.De. 1979); Carpenter v. Pennsylvania, 508 F. Supp. 148, 149 (E.D. Penna. 1981). But see Hewlett-Packard Co. v. Barnes, 425 F. Supp. 1294 (N.D. Calif, 1977), *aff'd* 571 F.2d 502 (9th Cir., 1978), *cert. den.* 439 U.S. 831 (1978); United States v. Bally Mfg. Corp., 345 F. Supp. 410, 423 (ED. La. 1972).

[17]Prout v. Starr, 188 U.S. 537, 543 (1903).

[18]The Constitution was ratified in 1788, and the first ten amendments were ratified in 1791. Dowling and Gunther, Consititutional Law 10 (1965).

powers of the Congress, is subject to the Fifth Amendment."[19]

As to the Ninth and Tenth Amendments, "a careful reading of the words and history ... indicates that they were intended to play a role in our constitutional scheme."[20] They can have meaning only if implemented to restrict the Federal Government. Administrative convenience or legislative tidiness cannot justify unconstitutional Federal action as this Court indicated in the legislative veto case, for example.[21]

The balancing of various constitutional provisisons is a common judicial experience,[22] as true of the Tenth

[19]Louisville Joint State Land Bank v. Radford, 295 U.S. 555, 589 (1935). The quoted portion in the text is followed by the following footnote in the Court's opinion:

> "[19]For instance, the war power, *Ex parte Milligan*, 4 Wall. 2, 119: *Ochoa v. Hernandez*, 230 U.S. 139, 153-4; *Hamilton v. Kentucky Distilleries Co.*, 251 U.S. 146, 155. The power to tax, *United States v. Railroad Co.*, 17 Wall. 322; *Boyd v. United States*, 116 U.S. 616; *Nichols v. Coolidge*, 274 U.S. 531, 542; *Blodgett v. Holden*, 275 U.S. 142, 147; *Barclay & Co. v. Edwards*, 267 U.S. 442, 450, *Heiner v. Donnan*, 285 U.S. 312, 326. The power to regulate commerce, *Monongahela Navigation Co. v. United States*, 148 U.S. 312, 336; *United States v. Joint Traffic Assn.*, 171 U.S. 505, 571; *Carroll v. Greenwich Insurance Co.*, 199 U.S. 401, 410; *United States v. Lynah*, 188 U.S. 445, 471; *United States v. Cress*, 243 U.S. 316, 326. The power to exclude aliens, *Wong Wing v. United States*, 163 U.S. 228, 236, 237-8. Compare *Perry v. United States*, 294 U.S. 330."

[20]Redlich, *Are there "Certain Rights...Retained by the People"?*, 37 N.Y.U.L. Rev. 787, 804-5 (1982).

[21]I.N.S. v. Chadha, 103 S.Ct. 2764, 2780-1 (1983)

[22]Peel v. Florida Dept. of Transportation, 600 F.2d 1070, 1084 (5th Cir. 1979) (Tenth Amendment and War Powers). See, e.g., Hostetter v. Idlewild Bon Voyage Liquor Corp., 377 U.S. 324 (1964); California v. LaRue, 409 U.S. 109, 115 (1972).

Amendment as of any other constitutional provisions. The judicial task of reconciling and accomodating seemingly conflicting constitutional provisions is well described as follows:

> "A person has the right not to have government act where it lacks power. In addition, he has other rights, which deny government power to act where otherwise it might. For example, the government has the power to regulate bankruptcy proccedings [U.S. Constitution, Art. 1, Section 8], but it lacks power to regulate them in such a way that a property owner is deprived of property without due process of law [*Louisville Bank v. Radford,* 295 U.S. 555 (1935)]. Though government has the power to preserve its own existence [*Dennis v. U.S.,* 341 U.S. 494, 501 (1951)], that power is tempered by the rights guaranteed by the first and fifth amendments [*Aptheker v. Secretary of State,* 378 U.S. 500 (1964)]. Similarly, where a person has an inherent right, recognized by the ninth amendment, it protects him against some exercise of power which might otherwise be proper ... It is in areas where government has power to act that it is important to the individual to have positive rights."[23]

These "positive rights" come within what Justice Douglas, for the Court in *Griswold,* called "penumbras, formed by emanations from those [Bill of Rights] guaranties that help give them life and substance."[24]

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[23]Comment, "The Ninth Amendment," 30 ALBANY L. REV. 89, 99 (1966).

[24]Griswold v. Connecticut, 381 U.S. 479, 484 (1965) (specifically referring to the Ninth Amendment as an example).

The Bill of Rights (including the Ninth and Tenth Amendments) has a special place and role in American constitutional interpretation, sedulously protected by this Court,[25] and guarded "with a jealous eye."[26] A liberal interpretation of such rights has been called "the only conclusion supported by history."[27]

In the instant case, the penumbra of the Tenth Amendment constitutionally authorize Massachusetts to determine what health benefits shall be provided to its residents under commercial health insurance policies, without hindrance by Federal preemption.

Federal Power in a True Emergency

Since constitutional interpretation involves balancing constitutional provisions,[28] the independent status of the Tenth Amendment as a restriction on Congress' powers need not prevent the Federal Government from acting where a true emergency requires national action. Justice Black analyzed the symbiotic relationship between the States and the central government as follows:

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[25]See, for example, Louisville Joint Stock Land Bank v. Radford, *supra* n. 19. Cf: Florida Lime and Avocado Growers, Inc. v. Paul, 373 U.S. 132, 151 (1963).

[26]A.F. of L. v. Swing, 312 U.S. 321, 325 (1941).

[27]Bridges v. California, 314 U.S. 252, 263, 265 (1941). See also Olmsted v. United States, 277 U.S. 438, at 471, 476 (1928).

[28]See Justice Blackmun's comment, concurring in National League of Cities v. Usery, 426 U.S. 833, 856 (1976); Peel v. Fla. Dept., *supra* n. 22 at 1084 and note 10.

> "The concept [of Federalism] does not mean blind deference to 'State Rights' any more than it means centralization of control over every important issue in our National Government and its courts. The Framers rejected both these courses. What the concept does represent is a system in which there is sensitivity to the legitimate interests of both State and National Governments, and in which the National Government, anxious though it may be to vindicate and protect federal rights and federal interests, always endeavors to do so in ways that will not unduly interfere with the legitimate interests of the States."[29]

Black's interpretation was cited with approval by Justice Connor, Chief Justice Burger and Justice Rehnquist.[30]

In *Steward Machine Co. v. Davis, supra* n. 15, dealing with the Federal Unemployment Compensation Act of 1935, the United States argued that the Nation was faced with a "problem which threatened the peace and solvency of local government, of the state governments, and of the national government." (p. 567). In balancing the constitutional provisions involved, the Court referred to a "crisis so extreme" (586) that it sent unemployment to "unprecedented

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[29]Younger v. Harris, 401 U.S. 37, 44 (1971).

[30]FERC v. Mississippi, 456 U.S. 742, at 796-7 (1983) (dissenting.)

heights", with a problem which "had become national in area and dimensions" thus presenting an "urgent need for some remedial expedient" (586-7).[31]

In contrast, however, in the record before the Court here, there is no showing whatsoever of any national emergency which threatens the Nation, the States or the national government. There is no constitutional basis, therefore, for balancing against the Tenth Amendment's full scope.

Does such a balancing in favor of the Tenth Amendment leave untidy constitutional or governmental edges in the exercise of power? Justice Cardozo dealt with such a problem:

> "In ruling as we do, we must leave many questions open ... Enough for the present purposes that wherever the line may be, this statute is within it. Definitions more precise must abide the wisdom of the future."[32]

This Court described ERISA's clause as a "virtually unique preemption provision."[33] In this light, it is well

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[31]See also Atchison Ry Co. v. United States, 284 U.S. 248 (1932); Home B. & L. Ass'n v. Blaisdell, 290 U.S. 398, 426, 444 (1934); National League of Cities v. Usery, *supra* n. 28, at 853; Allied Structural Steel Co. v. Spannous, 438 U.S. 234, 249 (1978).

[32]Steward Machine Co. v. Davis, *supra* n. 15, at 590. See also Kansas v. Colorado, 206 U.S. 47, 93 (1907).

[33]Franchise Tax Board v. Construction Laborers' Vacation Trust, 102 S. Ct. 2841, n. 26 (1983), cited with approval by Justice Connor (the Chief Justice and Rehnquist, J. concurring) in Shaw v. Delta Air Lines, 103 S. Ct., 2890, 3900 at *fn* 15 (1983), dissenting.

to heed the scholarly warning against "the futility of seeking to transfer generalizations from one area of regulation to another."[31] Another scholarly comment is also relevant: "a restriction on preemption in one particular field [of ERISA] may not by itself undermine the effectiveness of ERISA."[35]

Absent the most compelling reasons, which are wholly lacking in the record here, the Tenth Amendment is a limitation on the Commerce Clause and ERISA's preemption clause. "Enough for the present," as Cardozo advised.

This Court has recognized the nonfungibility of constitutional rulings because of factual differences in the cases. For example, the colloquy on oral argument by Solicitor General (later, Justice) Jackson in *State of Oklahoma v. Woodring:*

> "Mr. Jackson, Your Honors upheld the Social Security Act.
>
> The Chief Justice. I know. That is a special story on its own facts..."[36]

In a true emergency, Federal power can be effectively exercised as "a special story on its own facts" in the balancing of various constitutional provisions.

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[34]Hutchinson and Ifshin, Federal Preemption of State Law Under ERISA, 46 U. CHI. L. REV. 23, 80 (1978). This article was cited with approval in Shaw v. Delta Air Lines, 103 S. Ct. at 2901 note 19.

[35]Lockhart, Kamisar and Choper, Constitutional Law, Cases-Comments-Questions (1975, 4th ed.), 404.

[36]309 U.S. 623 (1940), Transcript of Proceedings, Jan. 29, 1940, Vol. 1, p. 81.

SYNERGISTIC EFFECT OF NINTH AMENDMENT

The constitutional impact of the Tenth Amendment, with its reservation of undelegated powers to the States "or to the People", is augmented and complemented in the instant case by the Ninth Amendment which provides for the retention of unenumerated powers "by the people". In *Kansas v. Colorado, supra,* the Court said that the principal purpose of the Tenth Amendment "was not a distribution of power between the United States and the States but a reservation to the people of all powers not granted."

The reach of both the Ninth and Tenth Amendments begins from the limited and non-exclusive grant of power of Congress in the Commerce Clause. Under the Ninth Amendment, "rights may arise or appear by reason of limitations placed upon or by limits of granted powers."[37]

In exercising its constitutional concurrent and shared power with the Federal Government, a State acting *in loco parentis* in behalf of its residents to assure them of comprehensive health care coverage in their health insurance policies, activates both peoples' reserved power under the Ninth Amendment[38] and their retained power under the Tenth, "for protection of individual liberty from infringements..."[39] from the Federal Government.

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[37]Kelsey, "The Ninth Amendment of the Federal Constitution," 11 IND. L. J. 309, 311 (1936).

[38]See concurring opinion of Justice Goldberg, the Chief Justice and Justice Brennan, Griswold v. Connecticut, *supra* n. 24, at 488, 492-4 (1965).

[39]Redlich, *supra* n. 20, at 808.

Amicus respectfully submits that the combined effect of the Ninth and Tenth Amendments constitutionally immunizes the statute of Massachusetts, acting in *loco parentis* for its "people", from preemption by the Federal ERISA statute. Notwithstanding the Commerce Clause, the rights sought to be protected by the State here come within what the Court, specifically mentioning the Ninth Amendment, called "...penumbras, formed by emanations from those [Bill of Rights] guaranties that help give them life and substance."[40]

CONCURRENT AND SHARED FEDERAL AND STATE POWER

There is no factual justification in the record for any constitutional claim of need for uniformity in connection with ERISA's preemption. The Commerce Clause contains no express authority for uniformity. When the Framers intended to authorize or madante uniformity, they did so in clear and specific terms. For example, in the Naturalization and Bankruptcies Clause, ART I, Section 8, Clause 4, the Constitution authorized Congress

> "To establish an *uniform* Rule of Naturalization, and *uniform* Laws on the subject of Bankruptcies throughout the United States." (emphasis added)[41]

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[40]Griswold, *supra* n. 24, at 484.

[41]Corwin, The Constitution (1953), 263. ("In the exercise of its bankruptcy powers Congress must not transgress the Fifth and Tenth Amendments.")

In the clause on duties, imports and excises, the Constitution mandates that they "shall be uniform throughout the United States", ART, I Sec. 3, Cl. 1..

Constitutional authorization for exclusive power was specific in the language of ART. I, Section 8, Clause 17, in connection with all cases whatsoever over the District of Columbia as the seat of the Federal Government. Likewise, "the sole power of impeachment" was given to the House of Representatives, ART. I, Sec. 2, Clause 5, and "the sole power to try all impeachments" to the Senate, ART. I, Sec 3, Clause 6.

Not only is there no showing anywhere in the record of a need that would "require exclusive jurisdiction by Congress'[42] but on the contrary Congress itself made it clear that there was no need for one uniform system in ERISA, by enacting a whole host of statutory exemptions and exceptions.[43]

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[42]Cooley v. Board of Wardens, 53 U.S. (12 How.) 299 (1851).

[43]Preemption does not apply to (1) any state law which "regulates insurance, banking, or securities," 29 U.S.C. 1144 (b) (2) (A); (2) to "any law of the United States," 1144 (d); (3) to any employee benefit plan established solely to comply with applicable workers' compensation laws, unemployment compensation laws, or disability insurance laws, 1003(b) (3); (4) to any plan established primarily to provide death benefits, 1144 (b)(2)(B); (5) to "any generally applicable criminal law of a State," 1144 (b) (4); (6) to "a governmental plan," "a church plan," and "an excess benefit plan," 1003(b); (7) to Hawaii's Prepaid Health Care Act, 1144 (6) (A); and (8) to certain multiple employer welfare arrangements, 1144 (6) (A) and (B). In addition, ERISA is inapplicable to state fair employment laws, Bucyrus-Erie Co. v. Department, 599 F.2d 205 (7th Cir., 1978).

Constitutional denial to Congress of exclusive authority or of a mandate for uniformity under the Commerce Clause, plus the absence of any showing of emergency requiring national preemptive power here, highlights the existence of constitutionally permissible concurrent State authority in areas where power is granted to Congress.

Such concurrent exercise of powers by States and the Federal Government is neither unique nor unusual. Despite the Copyright Clause's grant of power to the Congress, this Courts's first significant copyright decision sanctioned the concurrent exercise by States of "common law" copyright for unpublished works and by the Federal Government of statutory copyright for published works.[44] The Court has ruled that the copyright grant to Congress was not by its terms an "exclusive" grant,[45] thereby validating the constitutionality of concurrent Federal and State authority in a field where the Constitution specifically granted power to Congress.[46]

The rationale for the exercise of concurrent Federal and State power under the Constitution was clearly stated by Chief Justice Burger: "...our nation is simply too big and too diverse" for the Court to require a single national "community" standard[47] This

[44]Wheaton v. Peters, 33 U.S. (8 Peters) 591 (1834).

[45]Goldstein v. California, supra, n. 9.

[46]See NIMMER ON COPYRIGHT, Sec. 1.01 (B).

[47]Miller v. California, 413 U.S. 15, 30 (1973).

rationale applies equally to bar a Federal effort to establish a single national standard for what health benefits should or should not be required by all States in health or accident insurance covering their residents. The States have a constitutionally protected power to deal with the health and the physical and mental well-being of their residents without Federal preemption.

The Ninth and Tenth Amendments prescribe a governmental structure of concurrent and shared powers between the States and Federal Government. Power sharing inevitably leads to conflicts. Many such conflicts (as, for example, those between individual rights and the national interest or those between State and Federal rights) are contained within, and contemplated by, the Constitution. The Framers consciously left the conflicts to be resolved on a circumstance-by-circumstance basis responsive to the political and public policy views of the American people at any given moment in our history.[48]

[48]A distinguished legal philosopher said:

> "The most important issues that come before the Supreme Court are not questions of well-settled law but concern issues of public policy about which well-informed and well-disposed people differ."

Morris R. Cohen, Faith of a Liberal (1946) 180.

As a flexible charter designed for the future of a free people, the Constitution deliberately preserved such constructive tensions among concurrent power sources as a safety valve to guarantee that the National Government would be one of limited powers. The special, unique role of the Bill of Rights is to serve as a brake against forces, however well-meaning, which might jeopardize the rights of free people.

To this Court the Constitution delegated the delicate task of balancing rights in such conflicts between concurrent and often opposing power sources, in order to assure that they do not overreach their constitutionally intended and permissible boundaries.

Under this record, the Massachusetts statute under review has constitutional protection under the Ninth and Tenth Amendments against ERISA preemption.

CONCLUSION

The Court should affirm the decision below, specifically on the basis of the threshold issue that the Ninth and Tenth Amendments render ERISA's preemption provision unconstitutional.

Respectfully submitted,

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

METROPOLITAN LIFE INSURANCE COMPANY,
Appellant

v.

COMMONWEALTH OF MASSACHUSETTS,
Appellee

THE TRAVELERS INSURANCE COMPANY,
Appellant

v.

COMMONWEALTH OF MASSACHUSETTS,
Appellee

ON APPEALS FROM THE SUPREME JUDICIAL COURT OF MASSACHUSETTS

BRIEF AMICUS CURIAE OF AMERICAN OPTOMETRIC ASSOCIATION IN SUPPORT OF APPELLEE

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BRIEF AMICUS CURIAE OF AMERICAN OPTOMETRIC ASSOCIATION IN SUPPORT OF APPELLEE

The American Optometric Association submits this brief amicus curiae in support of appellee, the Commonwealth of Massachusetts. Letters granting consent, received from counsel of record for each of the parties, have been filed with the Clerk of this Court.

INTEREST OF AMERICAN OPTOMETRIC ASSOCIATION

The American Optometric Association, a nonprofit membership organization incorporated under Ohio law, is a national professional association of more than 25,000 members consisting of licensed Doctors of Optometry, optometry students, and educators. The Association's objects, as set forth in its Constitution, "are to improve the vision care and health of the public and to promote the art and science of the profession of optometry." The Association has as affiliates the state optometric associations in each of the 50 states and in the District of Columbia and the Armed Forces Optometric Society.

As the national professional organization representing the optometric profession, the Association has always been, and is now, vitally interested in matters which affect the adequacy of vision care available to the public. This includes, among other things, its interest in what is called "freedom of choice" legislation—that is, the widely-enacted state legislation which prevents insurance companies or others from discriminating against the practice of optometry and which likewise prevents discrimination against patients who wish to obtain vision care by utilizing the professional services of optometrists instead of physicians for those services within the lawful scope of the practice of optometry. The present cases may have a substantial impact on such matters.

SUMMARY OF ARGUMENT

ERISA has not preempted the mandated benefit provision of Section 47B of Massachusetts General Laws Chapter 175 (which requires that health benefit insurance policies shall include specified minimum benefits for mental and nervous conditions). No such issue was before this Court in *Shaw* v. *Delta Air Lines,* 103 S.Ct. 2890 (1983). Appellants' niggardly interpretation of ERISA's insurance exclusion clause—the clause which excludes from federal preemption "any law of any State which regulates insurance"—is contradicted by the plain meaning of the insurance exclusion clause and its background and by the settled federal policy, manifested particularly in the McCarran-Ferguson Act, of leaving to the states the regulation of insurance.

Appellant insurance companies, and the rest of the insurance industry, cannot rightly rely on ERISA to exempt or relieve them from Massachusetts Section 47B and other comparable state laws regulating insurance; the fair meaning of ERISA's insurance exclusion clause is to prevent just such escapes from being accomplished by the insurance industry.

Furthermore, it is submitted that, in any event, in disposing of these cases the Court should take particular care to avoid any intimation which might impair or cast a cloud on the validity of the widely-enacted state legislation known as "freedom of choice" legislation—which has been enacted in one form or another in nearly all the states. These freedom of choice statutes do not mandate that any particular health coverage be included in health benefit insurance policies or in uninsured employee benefit plans. But they do provide that if certain kinds of treatment (such as vision care) are covered, then such treatment must be covered regardless of the provider of the health services used (that is, in the case of vision care, regardless of whether the professional service is rendered by an optometrist or by a physician). With respect to plans operating through insurance policies, such state regulation is a regulation of insurance and should clearly be sustained under ERISA's insurance exclusion clause.

An additional ground for sustaining such a requirement for an insurance policy is that the freedom of choice statutes do not in any way interfere with or burden the area of federal supremacy which the ERISA regime was intended to establish. This additional ground would also sustain the freedom of choice statutes applicable in a number of states to those employee health benefit plans which do not involve insurance policies but are self-insured or self-funded and hence do not call into play ERISA's insurance exclusion clause. While this issue need not be addressed in these cases, the Court's attention is invited to the fact that the subject may well be involved in future litigation in this Court and that meanwhile it is important that the validity of these state statutory provisions not be impaired.

With respect to appellants' claim that Massachusetts Section 47B has been preempted by the National Labor Relations Act in cases where an employee health benefit plan is the outgrowth of collective bargaining, that claim has been adequately answered by the opinion of the Supreme Judicial Court of Massachusetts and is also being amply dealt with by the appellee's brief on the merits.

ARGUMENT IN SUPPORT OF AFFIRMANCE

The American Optometric Association has a strong interest in the disposition which the Court makes of these two cases.

The cases involve an important controversy as to whether federal law has preempted Section 47B of Massachusetts General Laws Chapter 175 which, as authoritatively interpreted by the Supreme Judicial Court of Massachusetts, expressly requires that insurance policies affording health benefits to Massachusetts

residents shall include specified minimum benefits for the care of mental and nervous conditions. There is no merit in appellants' claim that federal legislation precludes the application of Massachusetts Section 47B to insurance contracts covering Massachusetts residents.

Appellants, Metropolitan Life Insurance Company and The Travelers Insurance Company, are both engaged in the insurance business on a nationwide scale, including the business of writing health insurance policies on a group basis for employee benefit plans. Some of these insurance policies cover multi-state groups; many do not. The trial court's findings show that, at that time, over 140,000 employees residing in Massachusetts were known to be included in the employee health benefit insurance policies written by the two appellants alone (J.S.App. in No. 84-325 at 40a-42a), apart from the vast numbers of Massachusetts residents who are covered by such policies issued by other insurance companies. These circumstances underscore the reasons why Massachusetts has such a legitimate special concern to prevent the insurance industry from escaping the reach of a statute regulating insurance which Massachusetts has enacted in order to implement significant public policies of the Commonwealth.

The principal issue in these two cases turns on the fair scope of the preemption provisions in the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq.*, and of the express exclusions from preemption which Congress likewise provided for in that Act.[1] In Section 514(a) of ERISA, 29 U.S.C. § 1144(a),

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[1] A secondary claim made by the appellants is that, in situations where the health insurance policy for the particular employee benefit plan has resulted from collective bargaining, application of the Massachusetts statute is preempted by the National Labor Relations

Congress included the following provision as to preemption:

> "(a) Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title."

One of the areas expressly excluded from such preemption, however, is "any law of any State which regulates insurance." This appears in Section 514(b) of ERISA, 29 U.S.C. § 1144(b), which provides in part that:

> "(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."

Act, 29 U.S.C. §§ 151 *et seq.* The claim is developed, on behalf of both appellants, in the brief filed by appellant Travelers in No. 84-356. The claim appears to be nothing more than an unwarranted attempt at far-fetched extrapolation from this Court's rulings in *Teamsters* v. *Oliver,* 358 U.S. 283 (1959) and *Alessi* v. *Raybestos-Manhattan, Inc.,* 451 U.S. 504, 525-526 (1981). The total lack of substance to any such claim of NLRA preemption is demonstrated by the first opinion of the Supreme Judicial Court of Massachusetts in the present litigation (385 Mass. at , 433 N.E.2d at 1230-1233; see J.S. App. in No. 84-325 at 25a-31a), and is also, we understand, being amply dealt with in the brief on the merits being filed by the appellee, the Commonwealth of Massachusetts. Indeed, even the AFL-CIO, which has filed a brief amicus curiae supporting appellants' position on ERISA preemption, has felt compelled to voice its doubts (see AFL-CIO Br. at 5-6, note 1) concerning appellants' claim under the National Labor Relations Act.

Despite the fact that Metropolitan Life and Travelers are "persons" and are undeniably in the insurance business, despite the fact that the Massachusetts statute here in issue regulates the substantive contents of the health benefit insurance policies which appellants and other insurance companies may issue for coverage of Massachusetts residents, despite the fact that Massachusetts (like many other states) has a long tradition of regulating the substantive contents of insurance policies which an insurance company is permitted to issue,[2] the appellants nevertheless contend that ERISA's preemption provision has, in some magic fashion, operated to exempt and relieve the insurance industry from the operation of Massachusetts Section 47B whenever the insurance policy is tied in with an employee benefit plan. This, it is contended by appellants and by those amicus curiae briefs filed in support of appellants, follows from the analysis made by this Court in *Shaw* v. *Delta Air Lines,* 103 S.Ct. 2890 (1983), and from the emphasis in that opinion on the breadth of ERISA's preemption provision which had as an objective the giving of reasonable encouragement to uniformity in multi-state employee benefit plans.

But nothing in *Shaw* can possibly justify the niggardly interpretation which appellants would here impose on ERISA's insurance exclusion clause. The insurance exclusion clause was not at all before this Court in *Shaw* (as appellant Metropolitan Life acknowledges, Br. 19); it is now. It comes buttressed by a well-considered opinion of the Supreme Judicial Court of Massachusetts to the effect that, giving full range to *Shaw,* the applicability of the Massachusetts statute remains valid as a regulation of in-

---

[2]See the Massachusetts statutory provisions dating back at least to 1908 referred to in the Commonwealth's Motion to Dismiss or Affirm, filed October 5, 1984, at 21-22, note 8.

surance from which insurance companies are not exempted or relieved by ERISA. It involves a plain meaning—a principle of interpretation only the other day once more reaffirmed by this Court in *Garcia* v. *United States,* 105 S.Ct. 479, 482-483 (1984). There is nothing in the legislative history to contradict this plain meaning or to show that Congress had the slightest intention in 1974 to preempt state statutes which regulate insurance by requiring insurance companies to include certain minimum benefits in employee health insurance policies. Instead, there is an utter silence in the legislative history which appellant Metropolitan Life (Br. 37-38) seeks painfully to explain away.

Moreover, our view of the scope of ERISA's insurance exclusion clause is further buttressed by the well-known provisions in the McCarran-Ferguson Act, 15 U.S.C. §§ 1012(a) and (b), enacted in 1945, that "The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business," and that "No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance,[3] . . . unless such Act specifically relates to the business of insurance. . . ." Particularly in the present circumstances, this expression of

[3]*Compare Group Life & Health Ins. Co.* v. *Royal Drug Co.,* 440 U.S. 205, 215-216 (1979), stating:

> "Another commonly understood aspect of the business of insurance relates to the contract between the insurer and the insured. In enacting the McCarran-Ferguson Act Congress was concerned with:
>
> 'The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement—these were the core of the "business of insurance."' "

basic federal policy cannot be squared with appellants' efforts to escape the reach of Massachusetts Section 47B.

If this means that insurance companies are at some disadvantage, as against self-insured or self-funded plans, in competing for the business of employee benefit plans, the reason is that Congress deliberately chose to exclude from ERISA's preemption provision "any law of any State which regulates insurance." Faced with the need to balance the federal interest in encouraging the possibilities of uniformity for multi-state employee benefit plans as against the strong federal policy to leave the regulation of insurance to the states, Congress made a choice in favor of preserving the established rights of the states to regulate insurance. If the insurance industry or their supporters are dissatisfied with that resolution of the matter, their remedy would lie in an appeal to Congress, *compare Arizona* v. *Maricopa County Medical Society,* 457 U.S. 332, 354-355 (1982)—and perhaps they perceive the present Congress would not be very likely to shift from the choice an earlier Congress made when ERISA was enacted in 1974.

The present cases involve a particular mandated benefit which Massachusetts requires the insurance companies to offer with respect to the care of mental and nervous conditions. For the reasons we have summarized, and which are more fully developed both in the opinion of the Massachusetts Supreme Judicial Court and in the Commonwealth's brief as appellee, the Massachusetts statutory requirement that the insurance companies must include such a benefit in their health insurance policies should be sustained.

Similarly, if Massachusetts or some other state were to enact legislation that certain minimum vision care benefits

must be included in employee health insurance policies, it is the position of the American Optometric Association that such a mandated benefit provision should be sustained against comparable attack. We add, however, that we are not aware that any state presently has on its books a mandated benefit with respect to vision care. What is on the books is a vast body of state legislation, enacted in one form or another in about 48 states, which is known as "freedom of choice" legislation and which safeguards a patient's freedom of choice to select a provider of a particular health care service. With respect to vision care coverage which is provided for by an employee benefit plan, this means that the statutes of nearly all the states call for the reimbursement of the patient who utilizes the professional services of either an optometrist or a physician as long as the services performed come within what may lawfully be performed by a licensed optometrist under the laws of the particular state.

To assist the Court in its consideration of issues addressed by other briefs in the present cases, we invite the Court's attention to this vast body of state legislation and to its true nature. Appellant Metropolitan Life (Br. 3-4, note 5) discusses the variety of mandated benefit statutes—that is, state laws requiring health benefit insurance policies to provide coverage for a particular illness or condition—and refers also to the list of such mandated benefit statutes which Metropolitan Life cited at the jurisdictional statement stage (J.S. in No. 84-325 at 8-9, note 5)—none of which statutes involves mandated vision care.[4]

[4]Metropolitan Life also (Br. 4, note 5) refers to the survey of state statutes which had been submitted as an appendix to the brief amicus curiae filed September 29, 1984, by the Health Insurance Association of America at the jurisdictional statement stage. That Health Insurance Association brief in its Appendix IIA (at 3a), classifying mandated benefits by subject matter, correctly does not list vision care as a mandated benefit required by any state. However, its Appendix IIB (at 4a) may be inadvertently but distinctly misleading. It is entitled "State Laws Affecting Group Health Insurance Coverage for Services Rendered by a Particular Type of Health Care Provider." On the line for "Optometrist" it gives the figure "37" (meaning 37 states) in the column "Coverage Must Be Included in Group Policies" and the figure "2" in the column "Coverage Must Be Offered to Group Purchasers" and the figure "39" in the "Total" column. Then in Appendix III (at 5a-16a) these statutes are identified by state code citations and are listed by check marks under the column head "Must Be Included" or "Must Be Offered." (We accept the citations as being substantially accurate, although somewhat incomplete, and hence do not duplicate them by compiling an appendix of our own.) The net impression left on a reader who examines the Health Insurance Association tables might well be that these statutes generally mandate that health benefit insurance policies shall provide vision care benefits and that in order for such benefits to be obtained the services of an optometrist must be used. The actuality is quite different. The statutes do not mandate that vision care benefits shall be provided at all; instead they require in substance that whenever vision care benefits are provided, then the individual shall have freedom of choice to select either an optometrist or a physician with respect to any professional service which an optometrist may lawfully perform under the laws of the state.

Metropolitan Life correctly says (Br. 4, note 5) that "only mandated benefit statutes are at issue on this appeal"—and not those state statutes which specify that if certain kinds of treatment are covered by health insurance benefit policies, then such treatment must be covered regardless of the provider of the health services selected.

These latter are the freedom of choice statutory provisions which, as we have noted, have been enacted in nearly all the states to prevent discrimination in insurance policies against the utilization of the professional services of optometrists for vision care. These freedom of choice statutes represent deep-rooted policies of the states concerned. They are aimed at protecting the residents of the

states by assuring that more widespread vision care is available, by safeguarding the patient's freedom of choice, and indeed by discouraging monopolistic or restrictive practices by insurance companies and others which would tend to channel away from optometrists and to physicians the performance of vision care services which otherwise would flow to optometrists. *Compare Blue Shield of Virginia* v. *McCready,* 457 U.S. 465 (1982). Some of these statutes regulating insurance policies will be found in the portions of the state codes which deal with insurance; some will be found elsewhere. But wherever they are located in the state code, to the extent that they govern the provisions of health insurance benefit policies which may be written by insurance companies, they in any event come within the insurance exclusion clause of ERISA as a law "which regulates insurance" and hence on that ground alone are valid and not preempted by ERISA.[5]

There is also an additional ground, apart from ERISA's insurance exclusion clause, on which the American Optometric Association submits that the freedom of choice statutes should be sustained. This additional ground is that the nature of the freedom of choice statutes is not such that they burden the area of federal supremacy which the ERISA regime was intended to establish. *Compare Terminal Ass'n* v. *Trainmen,* 318 U.S. 1, 6-7 (1943); *Pacific Gas & Electric* v. *State Energy Resources Commission,* 103 S.Ct. 1713 (1983); *Arkansas Elec. Co-Op Corp.* v. *Arkansas Public Com'n,* 103 S.Ct. 1905 (1983). The state freedom of choice statutes do not impose on the par-

[5]With respect to any employee benefit plan which is the product of a collective bargaining agreement (see note 1, *supra*), we submit that any contention that a state freedom of choice statute has been preempted by the National Labor Relations Act would be wholly implausible and frivolous.

ties a substantive health coverage which the parties wish to avoid contracting for. Instead, the statutes assure that if vision care coverage is in fact contracted for, then there shall be no discrimination against persons who obtain such vision care by using the professional services of optometrists instead of physicians. The preemption issues which this Court canvassed in *Shaw* did not involve any such question; the question is not directly raised by the present cases which involve mandated benefits; and if it ever does come before the Court in some subsequent case, then there would be ample opportunity to develop the significant differences between the issues it raises and the issues which *Shaw* actually addressed.

This additional ground is of especial importance because some of the state legislation applies the freedom of choice principle to employee health benefit plans which are not incorporated into insurance policies written by insurance companies and to which the insurance exclusion clause of ERISA accordingly would not be germane. With respect to optometry, the freedom of choice legislation is applicable to non-insured plans (that is, to what are variously called self-insured or self-funded plans) in a number of states. For reasons we have indicated, it is the American Optometric Association's position that such freedom of choice legislation—which clearly was not before this Court in *Shaw*—was not preempted by ERISA and remains a valid exercise of state power for the implementation of important public policies of the states concerned.

It should be noted, moreover, that a considerable segment of the state freedom of choice legislation relating to vision care—some of it pertaining to insured plans only, some of it pertaining to plans not incorporated into insurance policies, and some of it pertaining to both—was

enacted during the 1960s, long before ERISA was passed in 1974.[6] Hence the total absence, in ERISA's legislative history, of any suggestion that Congress intended to preempt this well-known mass of freedom of choice legislation adds much weight to the other reasons for concluding that no such preemption has occurred.

We urge that in its disposition of the present cases the Court, in any event, should avoid any intimation which might impair or cast a cloud on the validity of the widely-adopted state freedom of choice legislation.

[6]Such freedom of choice legislation relating to vision care dating from the 1960s is to be found in at least 24 states—namely, Alabama, Arizona, California, Colorado, Hawaii, Idaho, Indiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Montana, Nebraska, New Hampshire, New Jersey, North Carolina, Oklahoma, Oregon, South Dakota, Tennessee, Utah, Washington, West Virginia—and from 1970 through 1973 in at least 10 additional states—namely, Arkansas, Florida, Kansas, Kentucky, Louisiana, Missouri, Nevada, New Mexico, New York, Virginia. (This is apart from the considerable body of freedom of choice legislation dating from those periods and relating to branches of health care other than vision care.) Accordingly, much of the freedom of choice legislation not only antedates the enactment of ERISA in 1974, but will be found well before March 1970. We mention March 1970 as a line of demarcation only because appellant Metropolitan Life (Br. 37, note 15), in its tortured effort to explain away the negatives and the silences confronting it in ERISA's legislative history with respect to mandated benefits, claims March 1970 as the date when the insurance exclusion clause first made its appearance in one of the predecessor bills which was not passed. Metropolitan Life, asserting that no mandated benefit statutes existed before March 1970, then contends (Br. 37-38) that the silence on the subject in the subsequent legislative history should be ignored. Even if the argument were meritorious — which we submit it clearly is not—it could not explain away the total lack of any manifested intention to preempt the freedom of choice statutes which were so widespread and so well-publicized before the March 1970 date

CONCLUSION

The judgment of the Supreme Judicial Court of Massachusetts was correct and should be affirmed.

Respectfully submitted,

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Nos. 84-325 and 84-356

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

METROPOLITAN LIFE INSURANCE COMPANY,
Appellant

v.

COMMONWEALTH OF MASSACHUSETTS

THE TRAVELERS INSURANCE COMPANY,
Appellant

v.

COMMONWEALTH OF MASSACHUSETTS

On Appeals from the Supreme Judicial Court for the Commonwealth of Massachusetts

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BRIEF AMICUS CURIAE OF THE NATIONAL ASSOCIATION OF ALCOHOLISM TREATMENT PROGRAMS, INC.

IN SUPPORT OF AFFIRMANCE

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QUESTION PRESENTED

Whether a Massachusetts law, Mass. Gen. Laws, Ch. 175, § 47B, mandating minimum health coverage by health insurance policies is preempted by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1144(a) *et seq.*, and the National Labor Relations Act ("NLRA"), 25 U.S.C. § 151 *et seq.*

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BRIEF AMICUS CURIAE OF THE NATIONAL ASSOCIATION OF ALCOHOLISM TREATMENT PROGRAMS, INC.

INTEREST OF AMICUS CURIAE

The National Association of Alcoholism Treatment Programs ("NAATP"), a not-for-profit corporation, is an association representing nearly 400 specialty hospitals, centers and units in 46 States dedicated exclusively to the treatment of the disease of alcoholism. The Association includes both not-for-profit and investor-owned entities. Health care services are offered by NAATP members in inpatient hospital, outpatient and freestanding residential settings. The primary goals of the organiza-

tion are to raise public awareness of alcoholism as a treatable disease; to promote and maintain the highest standards of health care in the treatment of alcoholism; to attain more adequate reimbursement for services; and to provide programs of continuing education to those who administer and coordinate alcoholism treatment programs. NAATP serves as official liaison from the alcoholism treatment field to the Joint Commission on Accreditation of Hospitals. NAATP's members, through their commitment to the organization's Principles of Practice, provide high quality care in this most crucial health area.

NAATP as well as its members have a vital interest in these appeals because they will resolve an issue that is of paramount interest to the mental health care field, in general, and specifically to the alcoholism treatment area —namely, whether Massachusetts (and other States) can mandate that health insurance policies covering that State's residents provide minimum benefits for the inpatient hospital, outpatient and residential treatment of certain treatable illnesses.

SUPPLEMENTAL STATEMENT OF THE CASE

The Commonwealth of Massachusetts' ("Commonwealth") brief on appeal discusses the issue of the inapplicability of preemption under ERISA and NLRA and the Committee for Comprehensive Insurance Coverage's ("CCIC") amicus curiae brief will discuss the same issues only limited to ERISA. NAATP joins in the Commonwealth's and the CCIC's arguments and incorporates them by reference in this brief. Although these cases directly involve mandated benefits relating to mental and nervous conditions, Mass. Gen. Laws, Ch. 175 § 47B, they indirectly will impact on similar mandatory coverage legislation, such as the Massachusetts laws relating to provision of alcoholism treatment coverage. Mass. Gen. Laws, Ch. 175 § 110; Ch. 176A § 10; Ch. 176B § 4A ½; Ch. 176G § 4.

In this brief, NAATP will catalogue the devastating human, economic and societal impact of alcoholism, demonstrate the recognition of alcoholism as a disease which should be and can be treated and discuss the consequential need to permit States to exercise their traditional insurance regulatory powers to mandate insurance coverage for treatable diseases. NAATP will also establish that, contrary to the insurance companies' apparent fears of negative financial impact, the cost of neglecting alcoholism treatment far outweighs the costs of providing adequate treatment.

Accordingly, the NAATP submits this *amicus curiae* brief, with the consent of the parties, in support of the Appellee to urge this Court to affirm the judgment of the Supreme Judicial Court of Massachusetts.

SUMMARY OF ARGUMENT

These cases require the Court to decide whether States can mandate that health insurance policies issued within their borders must provide the insureds with certain enumerated minimum benefits for the treatment of chronic treatable diseases. It is a well established legal principle that such control over the terms of insurance contracts is an inextricable aspect of insurance regulation, which has traditionally been left with the sole discretion of States. As will be argued in the briefs of the Commonwealth and the CCIC, such entrenched sovereignty was not preempted by ERISA or NLRA.

In addition to those legal principles, however, the social, human and economic costs of treatable but inadequately covered diseases justify such State laws and regulations. Mental health and alcohol/drug abuse disorders have a profound and severe effect on our entire society. Although alcoholism is widely recognized as a disease by professional organizations and governmental bodies, alcoholics are nevertheless ignored by many insurance companies, despite the irony that treating alcoholism costs

less, in the long term, than treating the acute and chronic consequences of that disease.

The trend towards mandated benefit laws reflects the independent judgment of numerous legislatures that alcoholism, and similar disorders, must be treated to alleviate the tremendous fiscal and social costs to the individual alcoholic, his family and society. It also reflects the judgment of State insurance regulators that coverage of diseases such as alcoholism is an obligation of those very insurers which are granted licenses by the States to conduct business in those jurisdictions.

ARGUMENT

I. WIDESPREAD USE AND ADVERSE CONSEQUENCES OF ALCOHOL MANDATES TREATMENT AND COVERAGE OF ALCOHOLISM

The need for effective alcoholism treatment[1] is mandated by the extent of the use of alcohol in the United States. Indeed, alcohol is regarded as the most widely

[1] Alcoholism is understood "as a complex disease with biological, psychological, and social features and causes." Blume, Sheila B., M.D., "Public Policy Issues," *Alcoholism and Related Problems* (1984), at 180. Another commentator in the field of alcoholism has defined that term to mean "an illness caused by the prolonged ingestion of ethyl alcohol (especially in biologically vulnerable people) and manifested by a variety of harmful physical, mental, behavioral, and social effects." West, Louis Jolyon, M.D., "Alcoholism and Related Problems: An Overview," *Alcoholism and Related Problems* (1984) at 1. *See also* Pennsylvania Task Force on Substance Abuse and Insurance Benefits (March 1981), which at page 12 states: "The disease of alcoholism is characterized by physical and/or psychological dependence or addiction to alcohol. Alcohol abuse and/or alcoholism represents the use of alcoholic beverages in a manner that impairs health and/or results in a loss of ability to control actions and maintain a socially acceptable life adjustment." In *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed. 1980), at page 169, alcoholism (also known as alcohol dependence) is defined as "either a pattern of pathological alcohol use or impairment in social or occupational functioning due to alcohol, and either tolerance or withdrawal."

used and abused drug in the United States. As noted by one commentator, "[a]lcohol is a drug. It is the No. 1 drug of abuse in our society. Its only close rival is tobacco. Both are legal." Lundberg, George D., M.D., "Ethyl Alcohol—Ancient Plague and Modern Poison," *Journal of the American Medical Association* (October 12, 1984), ("JAMA") at 1911. The magnitude of alcohol consumption was starkly depicted by a finding in 1981 that the equivalent of approximately 2.77 gallons of pure alcohol was sold per person over the age of 14. National Institute for Alcohol Abuse and Alcoholism, *Fifth Special Report to the United States Congress on Alcohol and Health from the Secretary of Health and Human Services* (December 1983), at xiii ("Fifth Report"). Put another way, each person in this country consumes, each year, about 591 12-oz. cans of beer, 115 bottles of wine or 35 fifths of 80 proof whiskey, gin or vodka. *Id.* In reality, this level of consumption is concentrated because approximately one-third of adults abstain, one-third have about two drinks per week, and the remaining third consumes an average of 14 drinks per week. *Id.* The foregoing averages still do not paint an accurate picture considering the estimate that a tenth of the drinking population consumes one-half of the alcoholic beverages sold in the United States. *Id.*

The most alarming fact is that heavy use of alcohol is not restricted to adults. The *Fifth Report* states that approximately 56 percent of ninth graders have tried alcohol. By the time they have reached their senior year in high school, more than nine out of ten students have used alcohol. Approximately 41 percent of the high school seniors reported that they had consumed five or more drinks on a single occasion within two weeks of the survey. Six percent stated that they drink on a daily or nearly daily basis. *Id.*

Whether adults or children are involved, excessive alcohol consumption has serious, and costly, medical impli-

cations. Unfortunately, the consequences of alcoholism are neglected by many insurance companies due to their outmoded and unjustifiable views of the costs of insuring alcoholism treatment. Given the magnitude of the alcoholism problem, however, it actually costs less to provide such benefits than to treat alcoholism's acute and chronic consequences.

A. The Devastating Effects of Alcoholism Mandate Treatment and Coverage

The level and concentration of alcohol consumption have drastic effects on individuals who actually consume alcohol, as well as upon non-consuming innocent third parties. Only adequate treatment, facilitated by insurance coverage, can measurably reduce these dire effects.

(1) *Human Costs*

The ingestion of even small amounts of alcohol results in immediate short-term physical reactions in the body. In addition, the use of alcohol in large quantities over an extended period of time often results in irreversible damage to virtually every organ in the body.

Alcohol is immediately absorbed into the blood. The blood transports the alcohol to the brain where it depresses inhibitory responses and reduces muscle tension. Berkowitz, Howard; Arthur Leyland, Jr. and David Strachan, *Alcoholism Benefit Project: An Interim Report* (Blue Cross and Blue Shield, 1980) ("Interim Report") at I:13. As the quantity of alcohol in the bloodstream increases, the drinker's coordination decreases. Other immediate short-term effects are slurred speech and confused thought processes. Thus, the drinker becomes unable to communicate in a coherent manner. If a drinker continues to ingest alcohol, he will lose consciousness before he is able to consume enough alcohol to completely extinguish the activities of his central nervous system, the result of which would be death. In fact,

it is possible to die from alcohol ingestion if the individual drinks a large enough quantity to prevent the body from being able to metabolize the alcohol to non-toxic and non-sedating substances. *Interim Report* at I:13-14.

The digestive system, including the mouth, esophagus, stomach, intestine and pancreas, is adversely affected by the consumption of large quantities of alcohol. For instance, alcoholics have a larger risk of cancer of the mouth, tongue, pharynx and esophagus than non-alcoholics. *Fifth Report, supra,* at 45. The pancreas is often structurally changed by excessive alcohol intake. Chronic pancreatitis is observed in many alcoholics. Additionally, over half of the alcoholics without pancreatitis symptoms show some pathologic changes in the pancreas. *Fifth Report, supra,* at 47.

The liver also is highly affected by excessive alcohol consumption. Liver diseases, including cirrhosis and hepatitis, occur more frequently in alcoholics than in non-alcoholics. Cirrhosis was the eighth leading cause of death in the U.S. in 1979. *Fifth Report* at 7. Additionally, in a Canadian study, data showed that 80 percent of deaths due to liver disease were alcohol related. Wolf, Stewart G., M.D., "Alcohol and Health: The Wages of Excessive Drinking," *Alcoholism and Related Problems* (1984), at 31-32.

Excessive alcohol consumption adversely affects the heart and skeletal muscle systems of the body. The heart muscle's pumping action is decreased whenever alcohol is consumed. Thus, for instance, cardiomyopathy, a heart muscle disorder which is the result of damage to the heart, is found in as many as 50 percent of alcoholics who have ingested large quantities of alcohol over a long period of time. National Institute of Alcohol Abuse and Alcoholism, *Fourth Special Report to the United States Congress on Alcohol and Health From the Secretary of Health and Human Services* (January 1981) ("Fourth

Report") at 46. A direct correlation exists between hypertension and the daily ingestion of large amounts of alcohol and incidents of strokes. *Id.*, at 47.

The endocrine system also is damaged by the excessive use of alcohol. One 1980 study showed that 70 to 80 percent of alcoholic men have a decreased libido and/or impotence. *Fifth Report*, *supra* at 55. In female alcoholics, the ovaries fail to produce hormones resulting in the loss of secondary sex characteristics and infertility. Id., at 55. *See also* Institute of Medicine, *Alcoholism, Alcohol Abuse and Related Problems* (1980), at 55.

The nervous system is adversely affected by excessive alcohol intake. For instance, it has long been acknowledged that loss of brain cells results from alcoholism. Brain atrophy was found by Parsons (1977) to be present in 50 to 100 percent of alcoholics. *Fourth Report*, *supra*, at 53. *See also* Institute of Medicine, *Research on Mental Illness and Addictive Disorders* (October 1984), ("IOM 1984") at 27. In addition, neuropsychological impairment occurs in alcoholics. Thus, for instance, alcoholics perform lower on tests such as visual-spatial and perceptual-motor tests than their non-alcoholic counterparts. *Fourth Report*, *supra*, at 55.

The harmful effects of alcohol are not confined to the actual user. Children born to women who ingest large quantities of alcohol during pregnancy may suffer from a number of alcohol-related effects, including fetal alcohol syndrome. As a result infants suffering from this syndrome may exhibit retardation in growth; a pattern of abnormal features of the head and face; and abnormal neonatal behavior or mental retardation. As many as one to three infants per 1,000 may have fetal alcohol syndrome. *Fifth Report*, *supra*, at 70. *See also IOM 1984*, *supra*, at 26. Other alcohol-related effects on the unborn include miscarriage, lower birth weight and physical congenital anomalies.

Non-alcoholics also are directly harmed by alcoholism, because alcoholism is causally related to a large number of accidents. The National Highway Traffic Safety Administration ("NHTSA") maintains data relating to all traffic crashes in which a fatality occurred. In 1981, NHTSA reported that 43 percent of all fatal crashes involved alcohol. *Fifth Report*, *supra*, at 9. Frequently single-vehicle accidents are alcohol-related. In 1981, 41 percent of single-vehicle fatalities and 45 percent of single-vehicle accidents in the 16- to 24-year-old age group involved alcohol. *Id.*, at 9. Clearly the mix of alcohol and driving create a significant increase in traffic accidents.

The risk of accident to pedestrians increases two-fold if the pedestrian has a blood alcohol count above .10 percent and it increases five-fold if the blood alcohol content is above .20 percent. Research has shown that, of all fatally injured pedestrians, there was measurable blood alcohol content in 35 to 74 percent of the cases. *Fifth Report*, *supra*, at 85. Alcoholism even affects the safety of air transportation. For instance, the United States Transportation Safety Board in 1979 found that of 678 fatal plane crashes, 30 pilots were alcohol impaired. *Id.*, at 85.

Alcoholism also has negative effects on the family and may result in tragic social consequences. There is evidence to suggest that separation and divorce among alcoholics and their spouses is seven times that of the general population (Paolino and McGrady, 1977), *Fifth Report*, *supra*, at 89. It is also estimated that alcoholics have poor marital relationships in 33 to 40 percent of the cases. *Id.* In 45 to 60 percent of spouse abuse cases, alcohol is a factor. (Hamilton and Collins, 1981). *Id.*, at 91.

Children of alcoholics often have psychological problems which can be attributed in part to an alcoholic parent or parents. Those children may exhibit antisocial behavior with other children and also may have additional problems in school. (Sher and McGrady.) *Id.*, at 92. While no clear figures are available, it seems that alcohol is involved in anywhere from 11 to 17 percent of child abuse cases. *Id.*, at 91.

Several studies have shown that between 15 to 64 percent of attempted suicides involve persons drinking alcohol, while 30 to 80 percent of actual suicides are committed by persons who were under the influence of alcohol. *Alcoholism and Related Problems, supra,* at 12.

Alcoholics lose more time from work than non-alcoholics, the time they do work is less productive and marked by diminished job performance. Alcoholics also may affect others at work. For example, the alcoholic may not get along with his or her fellow workers and may not interact well with them. *Interim Report, supra,* at I:14-15. If an alcoholic is responsible for completing certain tasks which are left undone, he or she may cause others to be unable to finish their work. As will be discussed below, the social cost of such loss of productivity is immense.

In sum, the human costs of alcoholism are significant. Users and innocent third parties alike suffer pain, injury and death because of alcoholism. These human costs alone justify mandated insurance coverage of alcoholism treatment to insure that alcoholics receive adequate treatment.

(2) *Economic Costs Related to Alcoholism Are Severe*

In addition to the tremendous human costs stemming from alcoholism which alone mandate far more attention from a treatment and coverage point of view, there also

are economic costs of significant magnitude associated with this national health problem.[2] These severe economic costs are borne by society as a whole. These costs only begin with the statistic that Americans spent approximately $56 billion on alcoholic beverages in 1980 which constituted 2.8 percent of total consumption expenditures in the United States. Cook, Philip J., Ph.D., "The Economics of Alcohol Consumption and Abuse," *Alcoholism and Related Problems, supra,* at 57.[3]

In aggregate terms, one authoritative study analyzed the enormous societal costs of alcoholism, concluding that the expenditures due to excessive alcohol consumption in the United States were $49.37 billion in 1977, which is equivalent to over $82 billion in 1983. Cruze, et al., *Economic Costs to Society of Alcohol and Drug Abuse*

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[2] The Honorable Margaret M. Heckler, Secretary of Health and Human Services, aptly summarized the magnitude and the detrimental effects of alcoholism in the United States as follows: "[T]he price of alcohol abuse to the American people is appallingly high. And that price is paid by all of us. The cost to our economy has been estimated at over $49 billion each year. But the dollar cost is only the beginning. The cost in human pain and misery, disease, and death is still more staggering. Accidents on our streets and highways claim about 50,000 Americans' lives each year—leaving another 150,000 permanently disabled. Half of those tragedies are alcohol-related. Alcohol's role in disrupting family life is less easily documented, but few doubt that it is significant. One in three Americans surveyed last year felt that alcohol caused problems in his or her family." *Fifth Report, supra,* at v.

[3] For purposes of analysis, it is useful to distinguish between direct and indirect costs. Direct costs include such items as costs of prevention, treatment and rehabilitation. Indirect costs result from the loss of productivity flowing from the illness of alcoholism. There is a potential inverse relationship between direct and indirect costs. Specifically, as expenditures on prevention and treatment rise indirect costs of the disease will fall. Fein, Rashi, *Alcohol in America, The Price We Pay* (1984), at 21-22.

and Mental Illness (1977).[4] *See also* Berry, Boland, Smart and Kauch, *The Economic Cost of Alcohol-Abuse*

[4] These costs are set forth in the following chart:

ECONOMIC COSTS TO SOCIETY OF ALCOHOLISM

($ in millions)		1977	1983 equivalent
Core Costs			
Direct:			
Treatment		$ 5,637	$ 9,425
Alcoholism treated in specialty settings	$ 707		
Alcohol-related illness and trauma	$ 4,930		
Support (research, education, training, construction, insurance administration)		735	1,229
Indirect:			
Premature mortality		10,715	17,916
Morbidity resulting in reduced productivity,		26,074	43,596
Lost work time	$23,593		
Lost employment	$ 2,481		
Total Core Costs		$43,161	$72,166
Other Related Costs			
Direct:			
Motor vehicle crashes (funeral, legal/court, etc.)		$ 1,782	$ 2,979
Criminal justice system		1,685	2,817
Social Welfare program administration		142	237
Other (fire losses, fire protection, highway safety)		832	1,391
Indirect:			
Alcoholics incarceration		1,418	2,371
Others' lost worktime due to motor vehicle crashes		354	592
Total Other Related Costs		$ 6,213	$10,387
TOTAL ECONOMIC COSTS		$49,374	$82,553

Fein, *supra*, at 27.

1975 (1977). Almost 75 percent of the total costs in 1977 are attributed to indirect costs, *i.e.*, lost productivity due to the illness of alcoholism. One commentator aptly summarized the severe costs related to alcoholism:

> 1) Alcoholism is a very costly disease. Yet it is far, far costlier than most of us imagine since few of us appreciate its very substantial impact on productivity.
>
> 2) Productivity losses alone are four times the amount expended on treatment costs (including costs of medical care for alcohol-related conditions). When we take account of excess mortality and morbidity, crime, accidents, fire, and similar consequences of alcoholism, we find that collectively these costs are nine times the treatment costs. These ratios increase markedly if we limit treatment costs to alcoholism treatment only.
>
> 3) It is no exaggeration to suggest that the state of health of the American economy, as well as that of the society, is severely affected by the presence of alcohol abuse and alcoholism. It is also no exaggeration to suggest that the size of the expenditures on specific treatment of alcoholism (about $1.1 billion) bears little relation to the negative economic and social impacts of the disease.

Fein, *supra*, at 30.

The foregoing severe individual, social and economic costs can be avoided, or at least substantially lowered, with treatment of alcoholism. Treatment, however, to be effective must be covered by insurance policies similar to those policies ensuring availability of treatment for other less devastating illnesses. Although alcoholics may agree to be treated for this disease, "because of the inadequate [insurance] coverage, the alcoholic will have to pay much or all of the cost of treatment . . . It doesn't take much imagination to see that under these circumstances, many

alcoholics pressing to make ends meet will find one excuse or another to stay out of the treatment program." [5]

II. ALCOHOLISM IS WIDELY RECOGNIZED AS AN ILLNESS THAT MUST BE ADDRESSED

Although much of the insurance industry has failed to provide adequate coverage because of an erroneous assumption that such coverage will be too costly, virtually every segment of society, including the medical profession, Federal and State governments, has recognized that alcoholism is a treatable disease that must be adequately treated precisely to avoid its costly consequences.

A. The Medical Profession Has Recognized Alcoholism as a Treatable Illness

Alcoholism has long been recognized by health professionals [6] as a serious illness affecting millions of Americans each year. In 1956 the House of Delegates of the American Medical Association ("AMA") issued a statement explicitly acknowledging that alcoholism is an illness that falls within the profession of medical practice. It published in 1968 its *Manual on Alcoholism*, which has since been periodically revised to incorporate advances in the understanding and treatment of alcoholism. The AMA also has initiated efforts to increase the awareness of physicians and educate them about addictive disorders, such as alcoholism, by publishing its *Manual on Drug Abuse*. Focusing on the addiction problems in the medical profession, the AMA also has sponsored a series of conferences on the "impaired physician" in order "to stress the very important fact that alcoholism . . . can be successfully managed through humanistic and scientific treatment." [7]

As recently as 1984 the AMA's Center for Health Policy polled physician's attitudes concerning alcohol abuse. Commenting on that poll, JAMA notes that "the respondents almost unanimously believed that alcoholism is a major national (indeed international) problem and that *it is a disease entity.*" (Emphasis added.) "Alcoholism—A Problem in Perspective" *supra* at 1912. Nevertheless, the need for treatment and coverage is as acute today as ever. Given the magnitude of the problem, treatment and coverage must be expanded dramatically.[8]

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[5] *The 1982 Report on Drug Abuse and Alcoholism*, Joseph A. Califano, Jr. (1982) ("1982 Report), at 223.

[6] Former Secretary of Health, Education and Welfare, Joseph A. Califano, Jr., summarized the extent of the disease by noting that: "Alcoholism is one of America's four top diseases. In the deaths it causes, the number of people it grips, and the economic toll it exacts, alcoholism is gaining fast on heart and circulatory disease, cancer and respiratory illnesses. If we don't act now to fight the disease with prevention, treatment, and research, alcoholism could be America's number-one disease in less than twenty years, before the end of this century." *1982 Report, supra*, 147.

[7] Niven, Robert G., M.D., "Alcoholism—A Problem in Perspective," *JAMA* (October 12, 1984), at 1912 (Dr. Niven is the Director of the National Institute on Alcohol Abuse and Alcoholism).

[8] NAATP has testified before the Congress on the urgency to treat the devastating illness of alcoholism: "It is known that alcoholism and alcohol abuse contribute to some 25 other known diseases, including cirrhosis, heart disease, pancreatitis, gastritis, peripheral neuropathy, and others. In addition, research indicates that more than 20% of all hospital admissions comprise patients with alcohol-related problems. This equates to an estimated $65.6 million spent daily treating the consequences of alcoholism while comparatively few of these patients are ever treated or even diagnosed for their primary disease: alcoholism. In fact, the National Institute on Alcohol Abuse and Alcoholism estimates that only 15% of alcoholics in need of treatment ever receive that treatment—a statistic which has not changed since 1974. *That more persons are treated annually for the consequences of alcoholism than for alcoholism, while 85% of alcoholics are never treated at all, indicates a need for expansion of services and coverage for alcoholism treatment.*" (Emphasis added.) Statement of NAATP, Robert A. Rundio, President, before the Subcommittee on Compensation and Employee Benefits, United States House of Representatives, on H.R. 656 "The Federal Employees Health Benefits Reform Act of 1983," July 28, 1983.

B. The Congress Has Recognized That Alcoholism Is an Illness of a National Magnitude That Must Be Addressed

After comprehensive hearings and extensive deliberation, the Congress has recognized that alcoholism and all of its adverse consequences constitute a severe national problem and, thus, has appropriated large sums of money to research and facilitate the treatment of the disease. It took the initiative in dealing with this national problem in 1968 by enacting the Alcoholic Rehabilitation Act of 1968, Pub. L. No. 90-574, 82 Stat. 1006 (1968) stating that "[a]lcoholism is a major *health* and *social* problem." (Emphasis added). 42 U.S.C. § 2688e(a)(1) (Omitted). Congress further declared that "[t]he handling of chronic alcoholics within the system of criminal justice perpetuates and aggravates the broad problem of alcoholism *whereas treating it as a health problem permits early detection and prevention . . . and effective treatment and rehabilitation . . . .*" (Emphasis added). 42 U.S.C. § 2688e(a)(3) (Omitted).

Subsequently on December 31, 1970, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, Pub. L. No. 91-616, 84 Stat. 1848 (1970) was passed requiring the Federal government to have alcoholism treatment programs for its employees. 42 U.S.C. § 290dd-1(a). It also established the National Institute on Alcohol Abuse and Alcoholism ("NIAAA") to study and promote the treatment of alcoholism. 42 U.S.C. § 290aa-1(a). That agency has played a continuing vital role in raising the level of awareness of this national health disaster. Federal law also provides that Federally qualified health maintenance organizations must provide alcoholism treatment services for their enrollees. The Federal Medicare program covers up to 21 days of inpatient treatment of alcoholism under 42 U.S.C. § 1395y(a)(1). Alcoholism treatment for members of the Armed Forces is also required in 10 U.S.C.

§ 1090. Moreover, the Civilian Health and Medical Program of the Uniform Services ("CHAMPUS") provides coverage for alcoholism treatment for spouses and children of active, retired or deceased members of the armed services in 10 U.S.C. § 1079 and the implementing regulations, 32 C.F.R. 199.10(b)(4). In addition, the Congress' concern with alcoholism is reflected in its fiscal 1985 appropriations for NIAAA in the amount of approximately $61 million for research into the causes and treatment of this debilitating illness.[9]

C. State Legislatures Have Mandated the Coverage of the Disease of Alcoholism

Although numerous professional organizations, as well as the Federal government, have come to recognize alcoholism as a disease that must be addressed, the insurance industry has not kept pace because of an unfounded fear that adequate coverage will result in higher costs to the industry. As noted by the National Coalition for Adequate Alcoholism Programs, ". . . coverage remains minimal. We are a long way from a comprehensive approach, and there is resistance by some insurance carriers and purchasers of group policies." National Coalition for Ade-

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[9] Even the Federal courts have recognized that alcoholism is a disease which cannot form the basis of a crime but which must be treated. The United States Court of Appeals for the Fourth Circuit, in a leading opinion, held that a chronic alcoholic could not be convicted and sentenced for public drunkenness. Driver v. Hinnant, 356 F.2d 761, 763 (4th Cir. 1966). In so holding, the court found that alcoholism is a chronic disease and that alcohol can be addictive. *Id.* at 763-764. Easter v. District of Columbia, 361 F.2d 50 (D.C. Cir. 1966). *See* Whitlock v. Donovan, —— F. Supp. —— (D.D.C. 1984, No. 83-3388), Gesell, J. ("An alcoholic has a disease. He is the victim of a handicap which becomes progressively worse unless successfully treated."); *cf.* Robinson v. California, 370 U.S. 660 (1962), *reh. denied*, 371 U.S. 905 (1962) (drug addiction cannot be punished as a crime). Alcoholism also has been held to be a handicapping condition for purposes of the prohibitions of discrimination of handicapped individuals contained in the Rehabilitation Act of 1973, 29 U.S.C. § 791 *et seq.*, *Whitlock* v. *Donovan, supra.*

quate Alcoholism Programs, *Conference Proceedings, Alcoholism Insurance Coverage*, Washington, D.C. (January 9, 1980), at ii. As a result of this unenlightened attitude by insurance companies, thirty-seven State legislatures enacted legislation mandating insurance coverage for alcoholism treatment or mandating optional coverage.[10] These statutes merely mandate *minimum* require-

[10] Alabama, Code of Alabama, §§ 27-20A-1 to 27-20A-4 [1979]; California, West's Annotated California Code, Insurance Code: §§ 11512.14 and 10123.6, Health and Safety Code: § 1367.2 [1978]; Colorado, Colorado Revised Statutes, §§ 10-8-301 [1975] and 10-16-136 [1976]; Connecticut, Connecticut General Statutes, §§ 38-262b (1974), 38-373(a)(18) [1976], and 38-262f [1979]; Florida, Florida Statutes Annotated, § 627.669 [1982]; Hawaii, Hawaii Revised Statutes, § 393-7(c)(6) [1976]; Illinois, Illinois Annotated Statutes, Ch. 73, Para. 979(8) [1978]; Kansas, Kansas Statutes Annotated, Ch. 40-2, 105 [1977]; Kentucky, Kentucky Revised Statutes, § 304.18-130 to 304.18-180 [1980]; Louisiana, Louisiana Statutes Annotated, Revised Statutes, Title 22, § 215.5 (1982); Maine, Maine Revised Statutes Annotated, Title 24, § 2329; Title 24-A, § 2482; Title 28, § 475, sub-§ 2-A [1983]; Maryland, Annotated Code of Maryland, Art. 48A, § 490F [1981]; Massachusetts, Massachusetts General Law Annotated, Ch. 175, § 110; Ch. 176A, § 10; Ch. 176B, § 4A ½ [1982] and Ch. 176G, § 4 [1976]; Michigan, Michigan Compiled Laws Annotated, §§ 500.3425 and 500.3609a [1980]; Minnesota, Minnesota Statutes Annotated, § 62A.149 [1980]; Mississippi, Mississippi Code 1972 Annotated, §§ 83-9-27, 83-9-29, 83-9-31 and 83-9-35 [1974]; Missouri, Vernon's Annotated Missouri Statutes, § 376.779 [1980]; Montana, Montana Code Annotated, §§ 33-22-701 to 33-22-704 [1983]; Nebraska, Revised Statutes of Nebraska, 1980 Cumulative Supplement, §§ 44-769 to 44-781 [1980]; Nevada, Nevada Revised Statutes, Ch. 689A.030, Ch. 689A.046, Ch. 689B.030, Ch. 689B.036, Ch. 695B.180, Ch. 695B.194, Ch. 695C.170, Ch. 695C.174, and Ch. 608 [1983]; New Jersey, New Jersey Statutes Annotated, §§ 17B:26-2.1, 17B:27-46.1, 17:48-6a, 17:48A-7a [1977]; New Mexico, New Mexico Statutes Annotated, Ch. 64, Laws 1983 [1983]; New York, Consolidated Laws of New York, Annotated, Insurance Law, § 162(17) [1981]; North Carolina, General Statutes of North Carolina, § 58-251.6 [1984]; North Dakota, North Dakota Century Code Annotated, §§ 26-39-01 to 26-39-05 [1975]; Ohio, Ohio Revised Code Annotated, §§ 1739.01, 1737.20, 1737.29, 1738.24, 1738.25, 1739.19, 1739.20, 3923.28, 3923.29, and 3923.30 [1982]; Oregon, Oregon Revised Statutes, §§ 430.010, 430.315 and 743.557 [1983]; Rhode Island, General Laws of Rhode Island, Ch. 27-38-1 to 27-38-8 [1980]; South Dakota, South Dakota Codified Laws, §§ 58-18-7.1 and 58-18-7.2 [1978]; 58-41-35.1 [1979]; Tennessee, Tennessee Code Annotated, § 56-7-1003 [1982]; Texas, Vernon's Annotated Texas Statutes, Insurance Code, Art. 3.51-9 [1981]; Utah, Utah Code Annotated, § 31-20-2(6) [1981]; Vermont, Vermont Statutes Annotated, Title 8, §§ 4097 to 4100 [1981]; Virginia, Code of Virginia, §§ 38.1-348.7 [1979] and 38.1-348.8 [1978]; Washington, Revised Code of Washington, §§ 48.21.160, 48.21.190, 48.21.180 [1974], and 48.44.240 [1975]; West Virginia, West Virginia Code § 33-16-3c [1981]; Wisconsin, Wisconsin Statutes Annotated, § 632.89 [1977].

ments for alcoholism coverage. Thus, even where mandatory legislation is in effect "[r]estrictive statutes, regulations and policies continue to limit reimbursement . . . . For example, many States reduce public grant and contract funding if third-party reimbursement is received by a program. Other States place dollar limitations on benefits." National Institute for Alcohol Abuse and Alcoholism, "State Legislation on Health Insurance Coverage for Alcoholism Services: An Assessment," *Alcohol World* (Summer 1982), at 49.

To the extent that such mandatory laws exist, they generally accept the medical definition of alcoholism as a treatable disease which health insurance contracts often do not cover adequately. Such legislatures after careful deliberation have determined that the interests of their States' citizens "require that health insurance coverage be provided for the treatment of alcoholism." *Id.* The mandatory coverage statutes, thus, are "intended to facilitate early intervention into the illness and to result in cost and human savings for the individual citizen, the insurer and the State." *Id.*, at 49-50.

These laws generally fall into two categories: (1) legislation requiring certain health insurance policies to cover treatment of alcoholism; or (2) requiring the insurance carrier to make such coverage available to employers, organizations and other groups at their option.

All of the laws cover group insurance contracts, while some also govern individual insurance policies. Whatever form these State laws take, a number of compelling reasons justify such reasonable measures which are aimed at facilitating the treatment of a devastating and major disease in the United States.

III. ALCOHOLISM IS A TREATABLE DISEASE

The most persuasive medical argument in favor of mandatory coverage is that alcoholism can be, is, and indeed, should be treated. Such treatment falls into two categories, namely the setting of the treatment and the services provided during treatment.

A. Setting of Treatment

There are three general settings for alcoholism treatment: inpatient hospital care; outpatient care; and intermediate or residential care.

(1) *Inpatient Hospital Care Settings*

Inpatient hospital care settings generally accommodate patients with alcoholism who also suffer from the medical or psychiatric complications of alcoholism. These complications may include, but are not limited to, liver disease or psychotic diseases. These patients are under the care of a physician in an acute care bed located in a hospital or other similar medical facility. The immediate goal of this setting is to arrest the life-threatening complications of alcoholism. (This is the detoxification phase of a comprehensive treatment plan.) The second goal is to reach a psychological and social evaluation of the patient so that the physician and alcoholism counselors can establish a plan of treatment and rehabilitation for that particular patient, including after his or her discharge from the hospital. *Interim Report* at 1:36-37. *See also* Chafetz, Morris, "Alcoholism and Alcoholic Psychosis," *Comprehensive Textbook of Psychiatry-II* (1976), at 1,341.

The inpatient hospital care settings often play a critical role in alcoholism treatment by using the immediate medical crisis of the patient to motivate him or her towards long term sobriety. Indeed, studies demonstrate that the initial contacts with hospitalized alcoholics often make the critical difference in the patients' motivation to continue with alcoholism treatment. *Interim Report, supra*, at 1:37. *See also* Chafetz, Morris, "Motivation for Recovery in Alcoholism," *Alcoholism Behavioral Research* (1976); and Chafetz, Blane, Abram, Golner, Lacy, McCourt, Clark, and Meyers, "Establishing Treatment Relations with Alcoholics," *Journal of Mental and Nervous Diseases*, Volume 138 (1962), at 395-409.

(2) Outpatient Care Settings

Patients who are able to function in their usual environment but whose drinking habits have caused problems may be treated successfully in outpatient settings. These settings thus can either provide a follow-up therapy to patients leaving the hospital or intermediate settings or may serve as an alternative for more intensive care. Generally physicians, psychologists, social workers and alcoholism counselors are responsible for assisting the patient in these settings. Therapy in the outpatient settings is intended to help the patient solve current problems and to draw upon the support of those who have contact with the patient outside the treatment settings, such as family or employer, to help the patient remain sober. *Interim Report, supra*, at 1:40-41. *See also* Armor, Polich, and Stambul, *Alcoholism and Treatment* (1976), at 75. These settings often are found in general and specialty hospitals, alcoholism hospitals and other clinical settings.

(3) Intermediate or Residential Care Settings

The intermediate or residential care settings have been established for patients who are not suffering from acute physical or mental complications resulting from alcohol-

ism, but whose lack of adequate control necessitates treatment for their drinking problem in a drug-free setting. They provide structured settings intended to protect the patients from environmental stress and access to alcohol. By using a variety of optional modalities, such as psychotherapy, counseling, referral to Alcoholics Anonymous, and other patient and family education techniques, these settings are intended to alter the drinking behavior of the patients by changing the way he or she thinks or feels. These programs assess the patient's physical, psychological and social needs and develop a follow-up or alternative plan to supplement the therapeutic gains made during the residential stay. These programs are less intensive in their medical services, although they may exist in affiliation with general and specialty hospitals to treat the acute care patient, or with alcoholism treatment centers, community mental health centers and rehabilitation centers. *Interim Report, supra*, at I:38-39.

B. Alcoholism Treatment Services

There are three general alcoholism treatment services available to alcoholics. Acute phase services address medical emergencies and medical complications of alcoholism such as alcohol poisoning, which is acute alcohol intoxication when life threatening, and withdrawal syndrome. *Interim Report*, 1:45. Chronic phase services seek to modify the alcoholic's chronic drinking problem. These services usually include psychotherapy, counseling, family therapy, drug therapy, behavior therapy and referral to Alcoholics Anonymous. *Interim Report* at 1:47. Auxiliary services often found in inpatient and residential settings include board, occupational and recreational therapy. They may also provide outreach programs, follow-up and aftercare, consultation, and education. *Interim Report* at 1:53.

In summary, some patients respond to inpatient hospital care settings; some respond to outpatient care set-

tings and some to intermediate care settings. Whatever the setting or service, however, alcoholics can be successfully treated. *See* Office of Technology Assessment, "The Effectiveness and Costs of Alcoholism Treatment" (March 1983) ("OTA"). Early treatment of alcoholics results in lower medical costs and benefits not only the individual alcoholic and his immediate family, but also society as a whole. In order to facilitate treatment, however, insurance coverage is necessary.

IV. THE DISEASE OF ALCOHOLISM SHOULD BE COVERED BY INSURANCE POLICIES

There can be little doubt that alcoholism is a serious disease with severe consequences for the individual alcoholic and his or her family as well as for society as a whole. The disease of alcoholism, however, is treatable. In order to promote treatment, insurance coverage for such treatment should be made available to the disease's victims and States should be permitted to exercise their traditional insurance regulatory authority to mandate coverage. Most insurance companies, however, fail to provide adequate coverage. They historically have asserted that comprehensive benefits would increase premium costs, result in higher utilization of medical services by patients and that mandated insurance coverage law results in higher administrative costs to employers. The opposite is in fact the case.

Analyzing an NIAAA study which examined the cost implications of six model insurance benefit packages for alcoholism treatment, one commentator notes that when offset savings and other costs are considered insurance premium costs actually decrease. Fein, *supra*, at 55-56. He concludes that the "study makes it clear that the treatment of alcoholism, given its secondary effects, is a good buy: total health insurance premiums can decrease if alcoholism benefits are added to the insurance package." *Id.* at 56.

Equally puzzling is the insurance industry's concern that adding insurance benefits will increase utilization of medical services. A review of a summary of twelve studies concluded that alcoholism treatment was found to be "followed by reductions ranging from 26 percent to 69 percent in medical care utilization." Jones, Kenneth and Thomas Vischi, "Summary of Impact of Alcoholism Treatment on Medical Care Utilization and Cost," National Institute on Alcohol Abuse and Alcoholism (1979), at 1. Moreover, a "57% reduction in family member utilization following the initiation of treatment of alcoholic family members" was found. *Id.*

Alcoholics and their families use medical services, both inpatient and outpatient, more frequently than nonalcoholics. *Fifth Report* at 106. Yet current literature consistently reports that placing alcoholics in specific alcoholism treatment programs decreases their use of general medical services. *See* Regier, Darrell, M.D., "Epidemiology and Health Service Resource Allocation Policy for Alcohol, Drug Abuse and Mental Disorders," *Medical Benefits*, November 15, 1984, at 8. The primary treatment of alcoholism ultimately reduces the cost of medical coverage by elimination of recurring alcohol-related symptoms which need medical treatment. In other words, encouraging treatment of alcoholism by comprehensive insurance coverage actually would lower costs for the insurance industry.

Finally, employers also greatly benefit fiscally from adequate treatment of alcoholism. A 1979 report determined that following alcoholism treatment, the number of sick days taken by alcoholics decreased 38 to 47 percent. Fein, *supra*, at 55. As noted above, the detrimental effect of alcoholism on productivity is stunning and is yet another compelling reason to provide treatment for alcoholism and to encourage alcoholics to take advantage of such treatment.

One of the primary motivations to convince alcoholics to receive treatment is the provision of insurance coverage. Indeed, the costs of inpatient, residential and outpatient care should not be a disincentive to seek such care. An employee who recognizes that he or she has an alcohol problem may be reluctant to seek treatment if he or she is required to pay 100% of the costs. (This is not to say, however, that deductibles and coinsurance are not useful in providing alcoholics with a stake in their recovery.) The costs of adequate treatment may be an excuse to avoid treatment and if this reason is removed, the person may take advantage of treatment services. Most alcoholics do not seek treatment at all.

Early treatment, moreover, reduces costs as complications and health problems arising from alcoholism are forestalled. Sixty-sixth American Assembly, "Public Policy on Alcohol Problems—Final Report," *Alcoholism and Related Problems, supra.* "Shortening the course of the disease for the average alcoholic by even a few years would save billions of dollars and avoid much human misery, tragedy, and despair."[11] In a 1979 study, data kept over a four year span on twenty-six alcoholism treatment programs was reviewed. The study found that for each dollar invested in alcoholism treatment, two dollars were saved. Other studies have shown that reduced absenteeism of an alcoholic following treatment can result in over $1,000 savings. Additionally, employed alcoholics respond well to treatment and this results in a long period of sobriety. Thus, the cost savings increase as time goes on.[12]

In summary, available data demonstrate that the costs of not treating alcoholism exceed the cost of providing such treatment, particularly considering the indirect

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[11] Former Secretary of Health, Education and Welfare, Joseph Califano, *The 1982 Report on Drug Abuse and Alcoholism*, at 180.

[12] *Id.* at 177.

costs which are associated with the disease. *OTA*, *supra*, at 69. Employers have found that the costs of absenteeism, loss of productivity and training new persons to take over, permanently or temporarily, for the absent alcoholic, are greater than the costs for treating alcoholism.

V. CONCLUSION

For all of the foregoing reasons, the judgment of the Supreme Judicial Court of Massachusetts should be affirmed.

Respectfully submitted,

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

METROPOLITAN LIFE INSURANCE COMPANY,
Appellant

v.

COMMONWEALTH OF MASSACHUSETTS

On Appeal from the Supreme Judicial Court for the Commonwealth of Massachusetts

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BRIEF FOR COMMITTEE FOR COMPREHENSIVE INSURANCE COVERAGE, AMICUS CURIAE, IN SUPPORT OF APPELLEE

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INTEREST OF AMICUS CURIAE

The Committee for Comprehensive Insurance Coverage (hereinafter referred to as "Committee") is an *ad hoc* coalition of public and private groups organized by the National Mental Health Association to participate in this case. For the past decade, these groups have been active in presenting State legislatures with the facts concerning mandated benefit laws, particularly those involving coverage for mental illness and alcoholism and drug abuse.

The groups that comprise the Committee are as follows: the State of Texas, the State of North Dakota, National Mental Health Association, Alcohol and Drug Abuse Problems Association of North America, Inc., National Association of State Alcohol and Drug Abuse Di-

rectors, National Council on Alcoholism, Inc., American Mental Health Counselors Association, Association of Mental Health Administrators, Association of Psychiatric Outpatient Centers of America, International Association of Psycho-Social Rehabilitation Services, National Alliance for the Mentally Ill, National Association of State Mental Health Program Directors, National Council of Community Mental Health Centers, American Association for Marriage and Family Therapy, American Dental Association, American Nurses' Association, Inc., American Occupational Therapy Association, Inc., American Podiatry Association, Child Welfare League of America, Inc., Family Service America, National Association of Reimbursement Officers, National Association of Social Workers, Inc., National Federation of Societies for Clinical Social Work, Inc. A description of these groups is contained in an Appendix to this brief.

SUMMARY OF ARGUMENT

This case falls within the presumption that state responses to social problems affecting its residents are entitled to respect unless Congress has unmistakably intended otherwise. This is no less true with respect to the Employee Retirement Income Security Act of 1974 (hereinafter referred to as "ERISA"); despite the existence of a preemption provision, this Court has recognized the principle of dual sovereignty in both the language and holdings of its prior ERISA cases.

Unlike these prior cases, the law at issue here is within the plain meaning of the exception from preemption for laws regulating insurance. Contrary to appellant's novel interpretation of "traditional" insurance regulation, the courts have repeatedly held that mandating policy terms and/or imposing requirements on insurers to underwrite risk throughout the population are within the recognized power of the states to regulate insurance. There is no authority to the contrary.

Both the language and structure of the preemption provision indicate that the plain meaning of the savings clause represented a deliberate choice by Congress to sustain the full scope of insurance regulation. More generally, mandated benefit laws are related to Congress' contemporaneous consideration of national health insurance and were made known to Congress in that context. It is unlikely that Congress intended to resolve this crucial health insurance issue in pension reform legislation without a single indication.

Appellant's discussion of the ERISA preemption provision has ignored the fact that Congress dealt specifically with three aspects of state insurance regulation in the context of preemption, but nowhere indicated an intent to encroach on the much more fundamental authority of the states to regulate insurers. The change in the preemption provision made by the Conference Committee was primarily motivated by state regulation of prepaid legal service plans; there is no reason to believe that the change was in any way related to state regulation of insurance.

Appellant's interpretation is also inconsistent with the primary purpose of ERISA to extend participant protections. Its attempt to preempt any insurance law that indirectly affects the terms of an employee benefit plan would deprive participants of remedies under state law. The courts have repeatedly upheld such state insurance laws; the alternative would be chaotic and inconsistent decisions from federal courts fashioning a federal common law to replace specific statutory and judicial state insurance laws and interpretations.

Mental health and alcohol/drug abuse disorders present a widespread and costly human problem, despite recent progress in treatment techniques and societal attitudes. Mandated benefit laws are a key to that progress.

These laws provide a climate for resolution of the problems caused by these disorders by lowering the cost of coverage, accelerating the trend to outpatient treatment, improving access to treatment for those least able to afford it, and expressing societal recognition that these disorders are illnesses that can be treated.

Appellant's policy arguments are not supported by the evidence. Coverage for mental health and alcohol/drug abuse illnesses is not expensive, even without considering the savings in productivity and avoidance of costly treatment for related physical problems which result from treatment of the underlying causes. Nor is the administrative burden a meaningful negative consequence. Large employee benefit plans already are structured to deal with local and regional variations in costs and legal requirements. While mandated benefit laws do remove some discretion in choice of benefits, that is the essence of the insurance function of risk-sharing, and has particular applicability for mental health and alcohol/drug abuse disorders where individual denial of affliction is a serious problem. More generally, ERISA was not intended to insulate employee benefit plans from the marketplace in which every other purchaser of insurance must operate. Finally, there is no evidence that mandate laws are a significant factor in the decision to self-insure health benefits; even if it were, Congress in ERISA expressed support for self-insurance.

Mandated benefit laws are a part of the emerging governmental policy towards health care. Many of those urging preemption of state law here are in the forefront of urging more state control over the health care process in other respects. This is an issue best dealt with by the legislative branch, where it has been fully and fairly debated in dozens of states across the country. The Court should decline the invitation to overrule this inherently legislative judgment.

ARGUMENT

I. FEDERAL PREEMPTION OF STATE LAWS IS NOT FAVORED BY THE COURTS.

This Court has previously considered federal preemption of state law in a variety of contexts. While the decisions necessarily vary to comprehend individual fact patterns, several themes have emerged. First and foremost, the "exercise of federal supremacy is not lightly to be presumed." *New York State Dept. of Social Services* v. *Dublino*, 413 U.S. 405, 413 (1973), and preemption is "not favored in the absence of persuasive reasons." *Chicago & North Western Transportation Co.* v. *Kalo Brick & Tile Co.*, 450 U.S. 311, 317 (1981). This is particularly true where the area of law subject to the preemption claim is traditionally within the prerogative of the states:

> "Where, as here, the field which Congress is said to have pre-empted has been traditionally occupied by the States . . . 'we start with the assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress.' *Rice* v. *Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947).

Jones v. *Rath Packing Co.*, 430 U.S. 519, 525 (1977). The task of the Court is not to find an interpretation that ousts state law (as appellant urges here), but rather to "reconcile the operation of both statutory schemes." *Merrill Lynch, Pierce, Fenner & Smith, Inc.* v. *Ware*, 414 U.S. 117, 127 (1973).

Appellant has argued that this Court's decisions concerning ERISA have, in effect, reversed the historical presumption and enunciated an unequivocal rule that Congress intended to preempt all state laws affecting employee benefit plans. This misrepresents both the language and holdings of these cases.

In *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981), the Court considered whether a New Jersey law

prohibiting offsets from pension benefits for workers compensation payments was preempted by ERISA. The Court's affirmative holding followed a discussion of the legislative history of ERISA which showed that Congress had intended to permit such offsets. There is nothing noteworthy about a decision that holds that a state law in conflict with federal law is preempted. On the contrary, the Court prefaced its holding with a discussion of preemption generally, making it clear that the presumption against preemption remained the general rule under ERISA. *See* 451 U.S. at 522.

Similarly, the result in *Shaw* v. *Delta Airlines*, 103 S. Ct. 2890 (1983), does not aid appellant. In that case, the Court held that New York could not compel an employer to amend its existing employee benefit plan to comply with a disability benefits law mandating benefits, but that it could require the employer to provide the disputed coverage in some fashion because of the exemption in Section 4(b) of ERISA, 29 U.S.C. Section 1002(b), for plans "maintained solely for the purpose of complying with . . . disability insurance laws." Thus, the decision sustains the ability of the state to mandate benefits. Moreover, the decision provides more opportunity for states to mandate the provision of certain fringe benefits than is arguably present here because *Shaw* applies to an employer regardless of the funding mechanism it chooses, while this case affects only those employers which purchase insurance.[1] Perhaps most significantly, the Court demonstrated its historical presumption

[1] Thus, the protestations of appellant/*amici* concerning indirect regulation of employee benefits by the states should not be accorded any weight. As a general proposition, no state could, as appellant/*amici* suggest, prohibit workers compensation offsets because such laws would conflict with ERISA as interpreted by this Court in *Alessi*. Under *Shaw*, however, any state could require even self-insured employers to provide mental health or alcohol/drug abuse coverage under its disability laws, regardless of the outcome of this case.

against preemption by taking a circuitous route to save New York's law—a route which had seemingly been foreclosed only two years previously in *Alessi*.[2]

In sum, this Court's two previous ERISA decisions do not manifest any departure from the general presumption against preemption of state laws. On the contrary, in language and result, the Court has emphasized its commitment to respecting the sovereignty of the states.

II. STATE LAWS MANDATING THE CONTENTS OF INSURANCE POLICIES ARE WITHIN THE TRADITION OF INSURANCE REGULATION.

A. Mandating Policy Terms Is an Integral Part of the State Regulation of Insurance.

Forty years ago, the Court held that state insurance regulators had "full power to prescribe the forms of contract [and] the terms of protection of the insured." *Hoopeston Canning Co.* v. *Cullen*, 318 U.S. 313, 321 (1943). More recently, in *Securities and Exchange Commission* v. *National Securities, Inc.*, 393 U.S. 453, 460 (1969), the Court described state regulation of insurance as focussing on, among other things, "the type of policy which could be issued." Thus, this Court has recognized that control over insurance contracts is an integral part of insurance regulation, and this conclusion has permeated the courts in all jurisdictions. *See* 2A *Couch on Insurance 2d* Section 21:31 (Rev. Ed. 1984); 43 *Am. Jur.2d* Section 26 (1983 Supp.).

[2] In *Alessi*, the Court rejected the argument that the provisions of a state's workers compensation law (which appears in the same exemption in ERISA as the disability laws considered in *Shaw*) survived preemption, reasoning that that section exempts plans, not laws from ERISA. *See* 451 U.S. at 523, n. 20. This is no doubt a better reading of the statute: Congress could have reasonably believed that plans maintained "solely" to comply with those laws would be so pervasively regulated by the state as to obviate the need for federal regulation under ERISA. Had Congress intended to save the laws themselves, it would have done so in the savings clause within the preemption provision.

Appellant has fared poorly in state courts with this argument because those courts have a long history of dealing with state insurance regulation. As the Court of Appeals for the State of Maryland commented, in the course of rejecting an identical argument by appellant in a case presenting the issue here:

> "A great many of the regulations contained in the Maryland Insurance Code, as well as the insurance law of other states, are provisions mandating specific coverages in various types of insurance policies. Much of the litigation concerning state regulation of insurance involves statutory provisions requiring specified coverages in different classes of insurance policies."

Insurance Commissioner v. *Metropolitan Life Insurance Co.*, 463 A.2d 793 (Md. 1983).

B. Assuring Comprehensive Coverage of Risks Is an Integral Part of the State Regulation of Insurance.

This Court has recently held that spreading and underwriting risk are the "primary elements" of insurance. *Group Life & Health Ins. Co.* v. *Royal Drug Co.*, 440 U.S. 205, 211 (1979). This is true not only with respect to the operation of a single policy, but also to the function insurance plays in the larger social context—what one theorist has called the "socialization of risk." *See* Kimball, *The Purpose of Insurance Regulation: A Preliminary Inquiry in the Theory of Insurance Law*, 45 Minn. L. Rev. 471, 511-514 (1961). Not surprisingly, this concept has been reflected in state insurance regulation. As one regulator has commented:

> "[T]his attitude is most strongly expressed concerning those types of insurance coverages deemed to be social in nature—for example, automobile, homeowner, and health insurance. Government is now expected to strengthen or replace the private insurance mechanism when the shortage of coverage is serious. Thus, ready availability of adequate coverage in certain lines has emerged as a fundamental objective of insurance regulation."

Huff, *Development of Public Policy from the Viewpoint of a State Insurance Regulator*, 1975 Ins. L. J. 393, 395.

This Court has recognized and sanctioned the risk-spreading nature of insurance regulation. In *California Auto Association Inter-Insurance Bureau* v. *Maloney*, 341 U.S. 105 (1951), the Court held that a state may require insurers to participate in a compulsory assigned risk pool to assure the availability of insurance coverage. The Court noted the states' pervasive authority over insurers, including the requirement "that local needs be serviced by the business." *Id.* at 110. *See also Osborn* v. *Ozlin*, 310 U.S. 53, 65 (1940) (explaining the states' "special relation to insurance").

Relying on these precedents, a number of courts have upheld the validity of mandated benefit laws. For example, in *Health Insurance Association of America* v. *Harnett*, 376 N.E. 2d 1280, 1284 (N.Y. 1978), a unanimous court held that a law mandating maternity care coverage in health insurance contracts passed muster as an aspect of "the Legislature's regulatory authority over the insurance industry." *See also Insurers' Action Council, Inc.* v. *Markman*, 490 F. Supp. 921 (D. Minn. 1980), *aff'd*, 653 F.2d 344 (8th Cir. 1981); *American Family Life Assurance Co.* v. *Commissioner of Insurance*, 388 Mass. 468, 446 N.E.2d 1061 (1983); *Blue Cross of Virginia* v. *Commonwealth of Virginia*, 269 S.E.2d 827 (Va. 1980). No court has held that mandate laws exceed the authority of the states to regulate insurance.

There can be little dispute that both mandating policy terms and requiring the underwriting of risk across the population are well-recognized aspects of "traditional" insurance regulation. We urge the Court to refrain from sustaining appellant's attempt to cast doubt on an issue that has been conclusively and repeatedly resolved against it.

III. ERISA WAS NOT INTENDED TO PREEMPT MANDATED BENEFIT LAWS.

Nine courts have considered the issue before this Court—with the exception of one district court decision (now on appeal), all have sustained state mandated benefit laws. *See American Progressive Life & Health Insurance Co. of New York* v. *Corcoran*, 715 F.2d 784 (2d Cir. 1983); *Wayne Chemical Corp.* v. *Columbus Agency Service Corp.*, 567 F.2d 692 (7th Cir. 1977); *Wadsworth* v. *Whaland*, 562 F.2d 70 (1st Cir. 1977), *cert. den.*, 435 U.S. 980 (1980); *Insurers' Action Council, Inc.* v. *Heaton*, 423 F. Supp. 921 (D. Minn. 1976); *Attorney General* v. *The Travelers Insurance Co.*, 463 N.E. 2d 548 (Mass. 1984); *Insurance Commissioner* v. *Metropolitan Life Insurance Co.*, *supra*; *New Hampshire-Vt. Health Service* v. *Whaland*, 410 A.2d 642 (N.H. 1979); *Metropolitan Life Insurance Co.* v. *Whaland*, 410 A.2d 635 (N.H. 1979).[3] In addition, the Department of Labor, through the Solicitor General, has taken the position that mandated benefit laws are not preempted by ERISA. *See Memorandum for the United States as Amicus Curiae*, *Wadsworth* v. *Whaland*, 435 U.S. 980 (1978) (hereinafter cited as "*U.S. Memorandum*"). This near-unanimity from all sectors of the judicial system, supported by the opinion of the agency responsible for enforcement of ERISA, demonstrates the comparative strength of the legal arguments.

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[3] Appellant has argued that the *American Progressive* opinion involved only state regulation of maximum commissions for sales of life insurance, but it has ignored the court's additional holding that another law at issue which regulated "the terms of policies sold to [employee benefit] plans" was not preempted. *See* 715 F.2d at 787.

Similarly, appellant has argued that *Wayne Chemical* involved only an Indiana insurance law forbidding the sale of insurance without a certificate. The court, however, also sustained the applicability of a mandated benefit law which provides that all insurance policies must include a provision extending coverage to disabled minors.

A. Congress Was Aware of That Aspect of the Tradition of Insurance Regulation Which Includes Mandated Benefit Laws When It Enacted ERISA.

1. *The language and structure of the statute evidences Congress' awareness of the scope of state regulation.*

Appellant's case is based on the proposition that Congress intended to distinguish between different types of insurance regulation for purposes of the savings clause. No such distinction appears in the language. On the contrary, the clause applies to "any law of any state which regulates insurance"—hardly an expression of an intent to limit the type of law covered.[4]

The court's holding in *Wadsworth* v. *Whaland*, *supra*, was based primarily on an examination of the structure of the preemption provision. It recognized that the savings provision would be meaningless unless it saved from preemption state laws regulating insurance which also indirectly regulate employee benefit plans since no other state law regulating insurance would be subject to preemption under ERISA even in the absence of the savings provision. *See also U.S. Memorandum*, *supra*, at 6.

The language of the preemption provision also shows Congressional awareness of the scope of insurance regulation. Section 514(b)(2)(B), 29 U.S.C. 1144(b)(2)(B) —the so-called "deemer" clause—creates an exception to the savings clause for insurance regulation to prevent a state from regulating a self-insured employee benefit plan as an insurer. The language chosen by Congress is sig-

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[4] When Congress desires to make the kind of distinctions urged by appellant, it knows how to do so directly. In 1983, Congress amended the preemption provision to increase the authority of the states to regulate certain self-insured welfare plans. The amendment distinguishes between state insurance laws which assure that benefits will be paid when due and "any law of any state which regulates insurance." *See* P.L. 93-473, Title III, Section 382(b), 96 Stat. 2613, *codified*, 29 U.S.C. 1144(b)(6)(A).

nificant: it provides that an employee benefit plan shall not be deemed to be an insurance company "for purposes of any law of any state purporting to regulate insurance companies [or] *insurance contracts*" (emphasis added). Thus, Congress evidenced its awareness that insurance regulation extended to the contracts issued by insurers, as well as the insurers themselves.

2. The relationship of mandated benefit laws to national health insurance shows Congress' awareness of this aspect of insurance regulation.

As an Associate General Counsel of the Health Insurance Association of America ("HIAA") has written, "a great deal of activity took place with respect to minimum standards" in health insurance during the period 1972-1974. Peel, *Regulatory Developments in Minimum Standards for Health Insurance Policies*, 13 Forum 680, 681 (1978). These included model acts and regulations promulgated by the National Association of Insurance Commissioners ("NAIC") mandating benefits for individual health insurance coverages, catastrophic coverage, conversion requirements, and newborn coverage. *See* Hanson, *The Private Insurance Industry and State Insurance Regulatory Alternatives to Federally Enacted Comprehensive National Health Insurance Legislation*, 6 Toledo L. Rev. 677, 712-713 (1975); II *NAIC Proceedings* 430 (1973); I *NAIC Proceedings* 414, 425 (1974).

The NAIC had a twofold objective for the emphasis on mandated benefit laws in health insurance: one was to address a series of problems on the merits, particularly availability of adequate coverage for all persons; the other was to create a "viable alternative to national health insurance." II *NAIC Proceedings* 438 (1976). *See also* 128 Cong. Rec. H9608 (Dec. 18, 1982) (testimony of Sen. Matsunaga concerning the origin of the Hawaii mandated benefits law).

Congress was aware of this activity, and the reasons for it because the period of its consideration of ERISA coincided with its detailed examination of twenty-two separate bills dealing with national health insurance. In 1974, a representative of the NAIC testified before the House Ways & Means Committee—one of the committees then considering ERISA—about state regulatory efforts undertaken to respond to the issues highlighted by Congress in the national health insurance debate. In discussing mandated benefits, he stated: "This is definitely going to be the mainstream of legislative activity in health insurance at the state level this year and next year." *Hearings on National Health Insurance before the House Committee on Ways and Means*, 93d Cong., 2d Sess. 2647 (1974).

It is inconceivable that a Congress preoccupied with national health insurance would have been unaware of the maelstrom of activity on the state level concerning mandated benefits during 1972-1974 undertaken in response to its deliberations. It is equally inconceivable that it chose to resolve an issue of critical importance to its contemporaneous examination of national health insurance in the context of pension reform legislation without a single indication.

B. The History of the Preemption Provision Does Not Show Any Intent To Limit State Regulation of Insurance Contracts.

The legislative history of ERISA shows that Congress deliberately limited the authority of state insurance regulators in three areas: regulation of pension plans, regulation of self-insured trusts, and joint enforcement of ERISA. We contend that Congress did not also intend, *sub silentio*, to enact the further limitation urged by appellant.

1. Congress deliberately limited the authority of the states in three areas.

The ten years of Congressional deliberation that preceded ERISA's regulation of the private pension system sparked a number of states to enact comprehensive pen-

sion laws. *See Malone* v. *White Motor Corp.*, 435 U.S. 497 (1978). This became an area of contention between federal and state regulation of employee benefit plans. In 1973, the NAIC presented testimony describing the new pension legislation several states had enacted. *See Statement of Stanley C. DuRose, Jr., before the Subcommittee on Private Pension Plans, Senate Committee on Finance*, 93d Cong., 2d Sess. (1973). In the alternative, the NAIC sought a role in the administration and enforcement of the federal standards imposed by ERISA. *See id.*; II *NAIC Proceedings* 418 (1973). Congress, however, declined to adopt either suggestion, opting instead for federal minimum standards for pensions and cooperative enforcement arrangements between the Secretary of Labor and state officials. *See* ERISA Section 506, 29 U.S.C. 1146; S. Rep. No. 93-127, 93d Cong., 1st Sess. 35 (1973).

The third limitation was more controversial. As early as 1961, the NAIC had noted the trend towards self insurance of health and welfare benefits. I *NAIC Proceedings* 76 (1963). A number of states had responded by "deeming" self-insured trusts to be insurance companies under state law. *See* Goetz, *The Regulation of Uninsured Employee Welfare Plans Under State Insurance Laws*, 1967 Wis. L. Rev. 319. While ERISA was being considered, the highest courts in New York and Missouri accepted cases presenting this issue. *See State ex rel. Farmer* v. *Monsanto Co.*, 517 S.W. 2d 129 (Mo. 1975); *Mutual Life Ins. Co.* v. *New York State Tax Comm'n.*, 32 N.Y. 2d 348, 298 N.E. 2d 672 (1973).

The House responded by drafting the deemer provision. This made it clear that states could control neither the solvency of such trusts, nor their content. The Senate, however, did not address this issue, leaving the Conference Committee with the task of resolving the difference. A further measure of the controversy surrounding the issue is that the NAIC vigorously opposed the House pro-

vision and the Committee staff was evenly split. *See Staff of Conference Committee on H.R. 2, Summary of Differences Between the Senate Version & House Version of H.R. 2*, 93d Cong., 2d Sess. 33 (1974); Sullivan, *Regulatory Aspects of the ERISA of 1974*, 1974 Proc. Leg. Soc. Am. Life Conv. 15, 49-52.

2. *The Conference Committee version of preemption.*

Appellant's presentation of the floor debate on the Conference Report does not explain what impelled the conferees to make a change in the preemption provision. A number of commentators, including the then-Associate General Counsel of appellant Travelers Insurance Co. have reached the same conclusion: "The concern with a professional society or association seems, from the floor debate, to have been the major impetus behind the revised, compromise preemption provision." Okin, *Federal Preemption of State Law Under ERISA: An Examination of the Effects of the Federal Mandate in the Light of Authoritative Precedent Under the Supremacy Clause, the McCarran-Ferguson Act & the Legislative History*, 24 A. of Life Ins. Couns. Proc. 115, 149 (1976); *see also* Dowd & Herlihy, *ERISA and Preemption* (ABA 1975); Note, *The Effect of ERISA on Prepaid Legal Services*, 27 Baylor L. Rev. 566 (1975).

Appellant's editing of the floor debate has obscured this focus on state regulation of prepaid legal service. For example, the only laws specified by Representative Dent as targets of the revised preemption provision were those of "any professional society or association operating under code of law." 120 Cong. Rec. H8701 (Aug. 20, 1974). Similarly, Senator Williams explained that the revision was to prevent "state professional associations" from hindering the development of "prepaid legal service programs." 120 Cong. Rec. S15742 (Aug. 22, 1974).[5]

[5] Fearful that Representative Dent's zeal for saving prepaid legal service plans from state regulation had misrepresented the intent of the conferees, Senators Javits and Williams engaged in a clari-

Finally, Representative Dent noted that the conferees had "followed to a large extent the same approach" Congress took in the Health Maintenance Organizations Act of 1973 ("HMO Act") preemption provision. 120 Cong. Rec. H8701 (Aug. 20, 1974). That provision does not broadly preempt state law;[6] its intent is to prevent states from controlling the structure of HMO's, as state bar associations were doing with prepaid legal service plans. *See Symposium Issue—Prepaid Legal Services*, 27 Baylor L. Rev. 403 (1975).

We are not suggesting that preemption is limited to prepaid legal service plans, but there is also no reason to ignore the conferees' identification of the reason behind the expansion of the preemption provision. The Court should be wary of enlarging Congressional intent beyond the evidence, particularly in the area of insurance regulation. Congress was aware of the extent of that regulation of employee benefit plans and resolved the potential conflicts in several specific areas. It is hardly likely that a Congress that thoroughly debated the propriety of state regulation of the terms of contracts for self-insured plans also intended to encroach on the states' historical power over insurance companies and contracts *sub silentio*.

C. State Insurance Regulation Plays A Major Role In Effectuating The Purposes of ERISA.

State health insurance regulation, including mandated benefit laws, is not inconsistent with any provisions of

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fying colloquy on the Senate floor—another indication that that was the primary concern of the conferees. *See* 120 Cong. Rec. S15743 (Aug. 22, 1974).

[6] *See* 42 U.S.C. Section 300e-10. In fact, the HMO Act "anticipates concurrent state regulation." *Hewlett -Packard Co.* v. *Barnes*, 571 F.2d 502, 504 (9th Cir. 1978). Most states regulate HMO's extensively. *See* Recent Developments, *Health Maintenance Organizations Act of 1973—Federal Regulation and Support of Prepaid Group Health Care Plans—Preemption of Restrictive State Laws and Practices*, 27 Vand. L. Rev. 1043 (1974).

ERISA, and neither appellant nor *amici* cite any such provisions.[7] In contrast to regulation of pension plans, ERISA is virtually silent as to welfare plans, particularly the substantive content of them. The only conclusion that can be justifiably drawn from ERISA concerning welfare plans is that Congress did not see fit to enact any special protections for participants in those plans.

Subsequent judicial experience with ERISA demonstrates the reason for Congress' decision. Numerous courts have held that state insurance law supplements ERISA—that it, in appellant's words, affects "the relationship between the plan itself and the plan's beneficiaries"—by providing remedies to welfare plan participants. *See Taggart Corp.* v. *Life & Health Benefits Administration*, 617 F.2d 1208 (5th Cir. 1980); *Wayne Chemical Corp.* v. *Columbus Agency Service Corp., supra; Rehabilitation Institute* v. *Blue Cross & Blue Shield*, 5 E.B.C. 2265 (W.D. Pa. 1984); *McLaughlin* v. *Connecticut General Life Ins. Co.*, 656 F. Supp. 434 (N.D. Cal 1983); *Lederman* v. *Pacific Mutual Life Ins. Co.*, 494 F. Supp. 1020 (C.D. Cal. 1980). *See also Brief of the Secretary of Labor, Donovan* v. *Dillingham*, 688 F.2d 1367 (11th Cir. 1982) (*en banc*) (expressing position of Department of Labor that ERISA and state insurance law both provide remedies for participants of insured plans).

Thus, appellant's interpretation of the savings clause would not only affect mandated benefit laws; it would also deprive participants of substantive remedies currently available under state insurance law. Even assuming, *arguendo*, that Congress was concerned about disincentives to welfare plans, there can be no question that pro-

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[7] The only "inconsistency" claimed by appellant is that ERISA expresses a Congressional recognition of the voluntary nature of plans and the costs imposed upon them. But, the fragmentary evidence in the legislative history is directed at pension plans; there is no evidenec that Congress was concerned about disincentives to welfare plans arising from ERISA or state insurance law.

viding protections for participants was the single most important policy expressed in ERISA.

Appellant's interpretation, however, would do more than vitiate participant protections; it would lead to chaotic and inconsistent adjudications that would be in no one's interest, least of all appellant and *amici*. Aside from the difficulty of deciding what is "traditional" insurance regulation, we refer to the chaos created by the preemption of state laws providing remedies under insurance contracts.

This point is graphically demonstrated by comparing the district court and appellate court decisions in *Wayne Chemical Corp.* v. *Columbus Agency Service Corp.*, 426 F. Supp. 316 (N.D. Ind.), *aff'd*, 567 F.2d 692 (7th Cir. 1977). The issue was whether a disabled minor lost insurance coverage once he became nineteen years old. The district court held that an Indiana insurance statute extending coverage under such circumstances was preempted by ERISA, but that the same result should be reached under "federal common law." The court, however, expressed concern that this approach could result in excessive litigation costs and inconsistent results because of uncertainty about a court's notion of federal common law (426 F. Supp. at 321, 326). The court of appeals affirmed on a different basis, holding that the Indiana statute extending coverage was not preempted by ERISA. Not surprisingly, the court of appeals did not choose to follow the district court across the rocky terrain of fashioning a federal common law when there was a provision of state insurance law that applied specifically to the subject.

* * * *

There is much mischief in appellant's argument. It has suggested that this Court overrule decades of legal precedent concerning the scope of state insurance regulation, thereby simultaneously opening a hole in the heart of ERISA that will engage the ingenuity of federal

courts for years to come. It has suggested that the Court radically change its historical approach to preemption by encouraging legal "interpretation" created to ignore the absence of any indication that Congress intended to preempt certain laws. Where, as here, the statute, legislative history and judicial precedent all point to an answer that preserves the coordinate sovereignty of our system of government, the Court's direction should be clear.

IV. THE POLICY CONSIDERATIONS SUPPORT MANDATED BENEFIT LAWS.

A. Mandated Benefit Laws For Mental Health and Alcohol/Drug Abuse Coverage Are In the Public Interest.

Fifty years ago, alcoholism, drug abuse and mental illness were viewed as "different" from physical disorders. Causes were mysterious, cures rare, and social stigma was attached to victims. The medical establishment treated only the physical problems related to these diseases, while neglecting the less tangible underlying causes. *See* Cooper, *Private Health Insurance Benefits for Alcoholism, Drug Abuse and Mental Illness* (Intergovernmental Health Policy Project 1983).

Today, these problems are considered illnesses that are treatable by known therapies with effective cure rates. Unfortunately, these treatments have evolved in large measure because of the recognition by society of how widespread and costly these disorders are. It has been estimated that 28-39 percent of adults experience at least one mental health disorder in their lifetime,[8] while an estimated 14.7 million Americans suffer from alcoholism or problem drinking and their numbers are increasing by 400,000 a year.[9] The societal costs are staggering: an

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[8] Robins, *et al.*, *Lifetime Prevalence of Specific Psychiatric Disorders in Three Communities*, 41 Arch. Gen. Psych. 949 (1984).

[9] Fein, *Alcoholism in America: The Price We Pay* (Care Institute 1984).

estimated $23.6 billion in direct and $28.9 billion in indirect costs related to mental health; $11.9 billion direct and $97.1 billion indirect costs relating to alcoholism and substance abuse.[10]

As the prevalence and costs of these disorders have intruded into the collective awareness of society, treatment methods have undergone a radical transformation. In the 1930's, treatment for mental illness generally meant long-term institutionalization in a public facility. By the next decade, two major alternatives had emerged: the development of effective psychoactive drugs and a shift in care from institutions to community-based settings. *See* Sharfstein, et al., *Health Insurance and Psychiatric Care: Update and Appraisal* (Am. Psych. Press 1984) at 2-3.

A similar revolution has occurred in the treatment of alcoholism and substance abuse. As recently as twenty years ago, persons suffering from such disorders were not even allowed admission to general hospitals. *See* Rosenburg, *Survey of Health Insurance for Alcoholism: Inpatient Coverage* (1979). Today, community-based settings and outpatient facilities specializing in treatment for these disorders are well-known.

Despite the substantial progress in societal attitude and treatment methods, many perplexing problems remain. Two of the most serious—assuring adequate coverage to all of those in need and financing that coverage—

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[10] Harwood, *et al., Economic Costs to Society of Alcohol, Drug Abuse & Mental Illness—1980* (Research Triangle Institute 1984).

These costs include the facts that more people are admitted to hospitals because of these disorders than for any other illness; industry suffers reduced productivity (emotional illness accounts for more abstenteeism from work than any other illness, except for the common cold); alcohol and substance abuse disorders are linked to motor vehicle crashes and household and workplace accidents, and those afflicted commit a disproportionate amount of criminal acts.

are the motivating factors behind mandated benefits laws. As both the federal and state governments have concluded, it is not enough to recognize the severity of the problem and that solutions are available; one must also express the political will to make those solutions a reality.

The federal government's role in the treatment of mental health and alcohol/drug abuse disorders has been crucial. Congress has repeatedly acted to shift the focus of treatment away from institutionalization and to broaden coverage throughout the population. See Wirthin, *Trends in Patient Care Episodes in Mental Health Facilities 1955-1977* (NIMH 1980). Even more significant was the action of the Congress in the HMO Act, which is, in part, a mandated benefit law because it requires federally qualified HMO's to offer coverage for mental health and alcohol/drug abuse disorders. *See* 42 U.S.C. 300e-1(1). As the Senate Report explains:

> "The Committee heard impressive testimony concerning the inclusion of mental health services as a basic required benefit. The Committee views the inclusion of mental health service as . . . a wise investment of money and personnel. . . .
>
> The Committee has included preventive diagnostic and medical and psychological treatment of the abuse of or addiction to alcohol and drugs as a basic benefit requirement. The Committee wishes to emphasize its view that drug abuse and alcoholism are diseases and should be treated as such."

S. Rep. No. 93-129, 93d Cong., 1st Sess. (1973), *reprinted in* 2 U.S. Code Cong. & Ad. News 3044 (1973).

While Congress was attacking the problem by mandating benefits offered by federally-qualified HMO's, many states were doing precisely the same thing by mandating benefits offered by state-licensed insurance companies. Unlike the financing of other ailments, treatment of mental health and alcohol/drug abuse disorders has

been primarily public.[11] The predominant reason was that the insurance industry had failed to react to the evolution of societal attitude and treatment methods with respect to these diseases. Many insurers either offered no coverage at all, or limited coverage to treatment in a hospital, thereby impeding the trend to outpatient treatment. *See* Reed, et al., *Health Insurance & Psychiatric Care: Utilization and Cost* (Am. Psych. Press 1972); *Rosenburg, supra.* Even more distressing was that the relation of a lower soceoeconomic class to mental health and alcohol/drug abuse problems had been clearly established, leaving those most in need of treatment without the means of obtaining it. *See* Hollingshead, *et al., Social Class and Mental Illness* (John Wiley & Sons 1958).

Despite the posture of the insurance industry here, it has also recognized that the changes in public attitude and treatment methods must be reflected in its attitude towards insurance coverage. In 1968, the HIAA warned its members that "the absence of coverage for mental illness treatment can result in under-insurance," and recommended that insurers include coverage for mental illness, alcoholism and drug addiction. Follman, *Insurance Coverage for Mental Illness* (American. Man. Ass'n. 1970) at p. 58. The goal, according to Mr. Follman (then on the staff of the HIAA) was "to assure an adequate and pluralistic system of financing that will enable all persons to enter the mainstream of health care on an equal basis and with a reasonable level of quality assured." *Id.* at 37.

State mandate laws are intended to respond to that challenge through the insurance mechanism of spreading risk throughout the population. The Massachusetts law

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[11] *See, National Drug and Alcoholism Treatment Utilization Surveys: 1979-1982,* 8 Alcohol Health & Research World 44 (1983); Sharfstein, *et al., Health Insurance and Psychiatric Care: Update and Appraisal, supra* at 7.

at issue here is an example of why mandated benefit laws are an integral part of the fight against these illnesses. As the Superior Court found, the law has had the following effects:

> —recognition that mental illness is a national *health* problem with a staggering price tag;
>
> —a shift from in-patient to outpatient delivery of treatment;
>
> —an increase in treatment for poor, working and middle class persons; and
>
> —a shift in financing from the public to the private sector.

Appendix to Jurisdictional Statement 51a-53a.

In sum, we urge this Court to recognize both the reasons for and the effectiveness of mandated benefit laws in solving these important health problems.

B. The Policy Concerns Raised By Appellant Are Contradicted By The Evidence.

1. *Mandated benefit laws for mental health and alchohol/drug abuse are cost-effective.*

Amicus HIAA has asserted that mandated benefit laws raise the cost of insurance 10-20 percent. There is no citation to any authority that supports this assertion. In fact, the evidence is to the contrary.

First, one of the principal objectives of mandated benefit laws is to reduce the cost of coverage by eliminating adverse selection. Where only a few insurers in a market offer coverage for a particular disorder, those persons who need that coverage will choose that insurer in disproportionate numbers, and the insurer with the coverage must price it higher to account for the adverse selection of poor risks. But, where all insurers must offer the coverage, there is less risk of adverse selection

and the rates can be lowered to reflect the assumption that each insurer will attract a pool of average risks.[12]

Second, the evidence from a variety of sources is that coverage for mental health and alcohol/drug abuse disorders is not expensive compared to the total cost of insurance, and is nowhere near the "estimate" provided by HIAA to the Court. This is true for both mental health[13] and alcohol/drug abuse.[14] Mandated benefit laws moderate that cost by providing a financing base and encouraging use of less expensive outpatient services.[15]

Finally, no discussion of cost can ignore the "offset" effect of treatment for these disorders. This includes benefits to employers in the form of improved productivity and reduced absenteeism.[16] It also includes the reduction in health care costs associated with treating physical ailments related to these disorders.[17]

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[12] The effect of mandated benefit laws on adverse selection and the cost of insurance was the subject of expert testimony in Superior Court (Joint Appendix 225-230) and a finding of that court (Appendix to Jurisdictional Statement 51a).

[13] See *e.g.*, VonKorff, *et al., Mental and Nervous Disorders: Utilization and Cost Survey* (NIMH 1979); Reed, *et al., Health Insurance and Psychiatric Care: Utilization and Cost, supra*; Jameson, *The Effects of Outpatient Psychiatric Utilization on the Costs of Providing Third-Party Coverage,* 16 Medical Care 383 (1978); Lowery, *et al., Analysis of Insurance for Mental Disorder,* 137 Am. J. of Psychiatry 9 (1980).

[14] See, e.g., Cooper, *Private Insurance Benefits for Alcoholism, Drug Abuse and Mental Illness, supra*; Holder, *et al., Medical Care and Alcoholism Costs and Utilization: A Five-Year Analysis of the California Pilot Project to Provide Health Insurance Coverage For Alcoholism* (1981); McCarthy, *Insurance Coverage for Treatment of Alcoholism: Analysis and Proposed Actions* (1982).

[15] *See* McGuire, *Mandated Mental Health Benefits in Private Health Insurance Policies: A Legal & Economic Analysis* (Yale U. 1981).

[16] *See* Barrie, et al., *Mental Distress As A Problem For Industry* (Springer-Verlay 1980); Jones, *et al., Summary of Impact of Alcoholism Treatment on Medical Care Utilization & Cost* (ADAMHA 1979).

In sum, the addition of coverage may increase the cost of insurance in the context of an individual case, but public policy is not based on one case, particularly in the area of insurance. Viewed from the perspective of social policy, coverage for mental health and alcohol/drug abuse illness is both inexpensive and cost-effective.

2. *Appellant*/amici *have overstated the administrative burdens.*

Appellant/*amici* have offered no data concerning the prevalence of totally uniform plans allegedly affected by mandate laws. As the Bureau of Labor Statistics has pointed out, benefits may well vary in establishments for a number of reasons. Indeed, "hospital, surgical, and medical benefits through Blue Cross and Blue Shield programs generally vary from locality to locality." U.S. Bureau of Labor Statistics, I *Digest of Selected Health & Insurance Plans, 1977-79 Edition,* p. vii (1978). In addition, virtually all large employers and Taft-Hartley plans include participants with at least two different types of health coverage. Pursuant to the HMO Act, 42 U.S.C. Section 300e-9, all employers and Taft-Hartley plans with more than twenty-five participants must offer employees the option to join an HMO.

Even within a supposed "uniform" health insurance contract, the plan cannot avoid local and regional differences and the administrative complexities those differences create. Under most major medical programs, reimbursement for physician fees is determined by usual, customary and reasonable criteria, established by the prevailing charges of practitioners in a geographic area for each procedure. Thus, a participant in New York

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[17] See, *e.g., Id.*; Mumford, *et al., A New Look at Evidence About Reduced Cost of Medical Utilization Following Mental Health Treatment,* 141 Am. J. of Psychiatry 1145 (1984).

who has an appendectomy will be charged, on the average, $875, while a participant in Wyoming will be charged $399.[18] Under the common UCR benefit structure, these participants will have different out-of-pocket costs, and the plan or insurance company will have to take the residence of the participant into account when paying the benefit.

Insurers and plans have been notably unsuccessful in arguing that variations in state laws create excessive administrative burdens. As the Superior Court concluded in this case after trial:

> "Mandated benefit laws do impose an administrative burden. However, the diversity of eligibility requirements for each state for example, would not be any more complex or burdensome to interstate commerce than various other diverse multi-state regulatory schemes such as workmen's compensation laws."

Appendix to Jurisdictional Statements 54a. Similarly, one court, after hearing evidence in a case brought by eleven insurers challenging Minnesota's mandated benefit law, concluded:

> "[T]he evidence indicates that insurance companies and employers with multistate group policies are regularly faced with meeting varying state requirements, and that the insurers can do so by merely attaching a rider or an endorsement which limits certain coverages to specific states."

Insurers' Action Council, Inc. v. *Markman, supra,* 490 F. Supp. at 928.

Benefit administration on the level of a multistate welfare plan is inherently a time-consuming, expensive and detailed task that is designed to deal with numerous

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[18] These figures are from the *Medicare Directory of Prevailing Charges 1983* (Health Care Financing Administration 1983) at pages 167, 275. .The Medicare Part B program uses a UCR system for paying benefits.

variables. Mandated benefit laws do not change that process; whether or not such laws exist, the plan must engage in the same administrative process applicable to all benefits. Appellant/*amici* have not proved how the addition of coverages would cause any significant additional cost or complexity.

3. *Freedom of choice of benefits is not a significant factor under ERISA.*

Many purchasers of insurance pay for coverages they do not need. That is one of the principles of insurance—to spread the risk across the population of those purchasing a policy to include persons who will never incur the risk insured against. Thus, the Court of Appeals for New York has held, in rejecting this argument against a mandated benefit law, that providing coverages to those who might not want it is part of the "concept—basic to insurance—of risk sharing." *Health Insurance Association of America* v. *Harnett, supra,* 376 N.E.2d at 1285.

Second, removal of choice is essential to providing adequate coverage for mental health and alcohol/drug abuse disorders. One of the most difficult problems in treating these illnesses is that those suffering from them deny that they have a problem, or are afraid to admit it because of the fear of adverse reactions from co-workers or their employer. In this respect, mandated benefit laws do not restrict choice as much as they remove the necessity of publicly announcing choice.

Finally, and most fundamentally, there is no indication that Congress intended to isolate employee benefit plans from the realities of the marketplace. The United States made this point clearly in its support of mandated benefit laws under ERISA: "Congress did not intend to confer any special exemption or privilege on [plans] as insurance buyers. Insurance sales to them must conform to the same rules as those to any other insurance buyer . . ." *U.S. Memorandum, supra,* at 8.

4. *Mandated benefit laws are not a significant factor in the decision to self-insure health benefits.*

The trend towards self-insurance began in the decade prior to the passage of ERISA. Congress' view was expressed in ERISA; there is no way to read the "deemer" clause as other than Congressional approval of self-insurance. Thus, even if appellant/*amici* were correct that mandated benefit laws encourage self-insurance, their argument would founder on the ground that discouraging self-insurance is not one of the policies expressed by Congress in ERISA.

Appellant/*amici* are not, however, correct in arguing that mandated benefit laws are a significant factor in the decision to self-insure. As the Superior Court found here:

> "There is no credible evidence that the potential cost impact of [the Massachusetts statute] has forced any policyholder of any insurance which has previously complied with [the statute] to discontinue such coverage and become a self-insurer . . .
>
> There is no credible evidence that the trend towards self-insurance is more pronounced in Massachusetts by virtue of the enactment of [the statute]."

Appendix to Jurisdictional Statement 55a.

Similarly, a New York study identified the following factors encouraging self-insurance: savings through a "one-shot" cash flow advantage due to the lag in first year claims; control of costs by assuming more direct administrative control over benefits; and investment yields of unused assets. *See* New York State Health Advisory Council and New York Business Group on Health, *Self-Insurance and Health Care Benefits in New York State: An Explanatory Statement and Descriptive Analysis* 17 (December, 1982). Its conclusion on mandate laws was direct:

> "Self-insured . . . plans generally responded that the 'burden of state insurance mandates' or 'redirection in mandated services' did not figure prominently in their decision to self-insure. . . ."

Id. at 21.

C. The Court Should Defer to the Legislative Branch to Resolve the Policy Considerations.

The groups which comprise the Committee are no strangers to the policy considerations presented by this case. We have been arguing them in State legislatures across the country—an arena in which the insurance industry, organized labor and large employers are not exactly unrepresented. The prevalence of mandated benefit laws is eloquent testimony to the merit of the two opposing points of view.

Whatever one's views, however, it is clear that policy arguments should be made to the legislative branch. This is particularly true with respect to regulation of health care. Faced with serious problems of cost and availability, government on all levels has begun to develop policies appropriate to its sphere of activities. Significantly, many of the *amici* which urge federal preemption of this state initiative are active participants in the effort to expand state regulation of health care into other areas, particularly controls over the price of health care services.

The ultimate direction of this evolution in health care policy is uncertain. One thing is, however, certain: the choices will follow the kind of thorough debate of policy considerations that forms the basis of any reasoned legislative decision—in short, the kind of debate that did not occur in the Congress which enacted ERISA.

We urge this Court not to fill this vacuum with its own judgment. As the United States concluded its discussion of this issue:

> "Congress preserved authority in the states to regulate insurance, and if petitioners find the result

burdensome their recourse is to Congress, or to the state legislatures, rather than to this Court."

U.S. Memorandum, supra, at 9.

CONCLUSION

For the foregoing reasons, we urge the Court to affirm the judgment of the court below.

Respectfully submitted,

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APPENDIX

APPENDIX

DESCRIPTION OF PARTICIPANTS IN THE COMMITTEE FOR COMPREHENSIVE INSURANCE COVERAGE

State of Texas

The State of Texas has enacted mandated benefit laws for treatment of alcohol and drug abuse disorders.

State of North Dakota

In 1975, the State of North Dakota enacted mandated benefit laws for treatment of mental health, alcohol and drug abuse disorders.

National Mental Health Association

Founded in 1909, the NMHA is the nation's largest consumer advocacy organization for mental health dedicated to promoting mental health, preventing mental illness, and improving the care and treatment of mentally ill individuals. The 650 Mental Health Association local chapters and state divisions and its more than one million citizen volunteers work toward these goals through a wide range of activities in social action, education, advocacy and public information.

Alcohol and Drug Problems Association of North America, Inc.

Since its formation in 1949, the ADPA has sought unity of action for the benefit of individuals who suffer from alcohol and drug related problems. ADPA is a membership association consisting of alcohol and drug abuse professionals in all sectors of the field. Its services include advocacy and leadership on national legislative and public policy issues, sponsorship of a variety of conferences and professional education opportunities, and

publication of newsletters and information designed to disseminate current field developments to professionals.

National Association of State
Alcohol and Drug Abuse Directors

NASADAD is a not-for-profit organization composed of directors of State alcoholism agencies and of single State agencies for drug abuse prevention. The association was originally incorporated in 1971 to serve State drug agency directors; in 1978, the membership was expanded to include State alcoholism agency directors. NASADAD's basic purpose is to foster and support the development of effective alcohol and drug abuse prevention and treatment programs throughout every State.

National Council on Alcoholism, Inc.

The NCA is the only national voluntary health organization founded to combat alcoholism. Since 1944, it has fought to reduce the stigma attached to this tragic disease and to gain recognition for it as a major national health problem. NCA's main activity is educating the public about alcoholism through its network of over 200 state and local affiliates. NCA offers vital information and referral services to alcoholics and their families, is their major advocate at the national policy-making level, and has been instrumental in the establishment of effective treatment services.

American Mental
Health Counselors Association

AMHCA is a multidisciplinary group of professional mental health counselors, working in a wide range of settings, dedicated to maintaining and improving the quality of mental health services and its providers by promoting licensure and certification, improved training standards, freedom of choice and client advocacy. AMHCA has sponsored the creation of the National Academy of Certified Clinical Mental Health Counselors, the recognized certification body for mental health counselors. With nearly 9,000 members, the American Mental Health Counselors Association is the second largest division of the American Association for Counseling and Development.

Association of
Mental Health Administrators

AMHA is composed of administrators of institutions, community mental health centers and programs dealing with mental illness, mental retardation, developmental disabilities, alcoholism and drug abuse.

•

Association of Psychiatric
Outpatient Centers of America

Membership consists of individual outpatient psychiatric centers. There are 109 members in the United States and Canada.

International Association of
Psycho-Social Rehabilitation Services

IAPSRS is a non-profit, membership association of organizations and individuals involved in providing community-oriented services to psychiatrically disabled adults. Primarily based in the United States, the Association's purpose is to advance the role, scope and quality of services designed to facilitate the community readjustment of the psychiatrically disabled.

National Alliance for the Mentally Ill

NAMI is a self-help movement of families, friends, and former mental patients that advocates for the chronically mentally ill, including research into the causes and treatment of mental illness and support services for mentally ill persons, and that provides information, education, and emotional support to families with a member afflicted

with serious mental illness. Since its inception in 1979, NAMI has rapidly developed into a national movement with 363 affiliates including 20 statewide associations in all 50 states with nearly 30,000 family members that are united in their common cause through the national office in Washington, D.C.

National Association of State Mental Health Program Directors

NASMHPD is the mental health arm of the National Governors' Association. The NASMHPD membership consists of the agencies in each of the 55 states and territories that administer and fund the state government programs serving mentally disabled persons. The NASMHPD member agencies expend $8 billion annually in the care of mentally ill people. Many of the member agencies also administer programs for the mentally retarded, developmentally disabled, alcohol abusers and drug abusers, totally an additional $5 billion.

National Council of Community Mental Health Centers

Founded in 1970, the National Council represents more than 700 agencies comprising some 62,000 staff and board members nationwide. Through its sections and divisions, the National Council also provides membership opportunities for individuals who share common interests in specialized areas of community mental health.

American Association for Marriage & Family Therapy

The Association represents over 11,000 family therapists. It sets high standards for clinical practice, promotes professional education, accredits educational and training programs, publishes professional journals, and is active in public policymaking.

American Dental Association

The ADA is a voluntary, nonprofit organization of 130,000 dentists dedicated to encourage the improvement of the health of the public and to promote the art and science of dentistry.

American Nurses' Association, Inc.

ANA is a not-for-profit professional organization representing approximately 180,000 registered nurses who are members of ANA's constituent associations in the 50 states, the District of Columbia, the Virgin Islands and Guam. Approximately 12,000 registered nurses are members of ANA's constitutent in the Commonwealth of Massachusetts. The Council on Psychiatric and Mental Health Nursing exists within the structure of ANA to foster high standards of psychiatric/mental health nursing practice and to facilitate the advancement of psychiatric/mental health nursing as a significant specialty in the mental health field.

American Occupational Therapy Association, Inc.

AOTA is a nonprofit association of health professionals that was founded in 1917 and now represents over 39,000 registered occupational therapists, certified occupational therapy assistants, and students of occupational therapy. Affiliated with the national Association are associations located in each state, the District of Columbia, and Puerto Rico. The health professionals represented by the AOTA specialize in increasing the independent functioning and productivity of people of all ages who are physically, psychologically, or developmentally disabled.

American Podiatry Association

APA is a professional society with 8,500 members in 52 component societies, one in each state, Puerto Rico, and the District of Columbia. It has two main objectives:

(1) to create greater public awareness of the benefits of good foot care; and (2) to encourage and initiate programs to meet the foot health needs of an expanding population.

Child Welfare League of America, Inc.

The League is a privately supported organization of over 300 child welfare agencies and 1200 affiliates whose efforts are directed to the improvement of care and services to children and their families. The League was the first national, not-for-profit voluntary membership organization which set standards for child welfare services in the United States and Canada. League member agencies provide a variety of services, including day care, residential and group care, foster family care, day treatment, protective services, maternity care, and shelter care.

Family Service America

FSA represents 280 family service agencies in the United States and Canada. Founded in 1911, it is the leading organization in the family service movement in North America. Through its member agencies, approximately 3 million persons annually receive direct services and programs to resolve issues of family life.

National Association of Reimbursement Officers

NARO is a professional organization of employees from small, medium, and large governmental agencies who are directly involved in multi-faceted private and public reimbursement programs. NARO members are public or nonprofit employees representing a cross section of many disciplines from states, counties, and communities. Core membership is directly engaged in or is responsible for reimbursement of costs related to governmental health care agencies. Other members are from medical and related services, legal services, and administrative services. This year NARO celebrates its thirtieth (30th) anniversary.

National Association of Social Workers, Inc.

NASW is a non-profit national organization of professional social workers which is devoted to the advancement of sound public policy for the consumers of social work services as well as for social work professionals. More than one-third of its 98,000 members are engaged in providing health and mental health services in public, voluntary and private institutional and outpatient settings throughout the country.

National Federation of Societies For Clinical Social Work, Inc.

NFSCSW is a federation of state organizations working to advance the interests of clinical social workers and their patients in state and federal mental health programs; increase the knowledge and skills of individual social workers through sponsorship of continuing education programs and professional publications; expand the availability and accessibility of mental health services by promoting the inclusion of clinical social workers as reimbursable providers of mental health services in group health insurance programs; and assure consistently high quality and integrity of services rendered to patients by promoting high standards for licensure and certification of clinical social workers.

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Nos. 84-325 and 84-356

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OCTOBER TERM, 1984

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AMICUS CURIAE BRIEF OF THE STATE OF CONNECTICUT, JOINED BY THE STATES OF CALIFORNIA, KANSAS, LOUISIANA, MAINE, MARYLAND, MICHIGAN, MINNESOTA, MONTANA, NEW JERSEY, NEW MEXICO, NEW YORK, NORTH CAROLINA, NORTH DAKOTA, SOUTH CAROLINA, VERMONT, WISCONSIN AND THE COMMONWEALTH OF VIRGINIA, IN SUPPORT OF APPELLEE

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IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1984

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INTEREST OF AMICI CURIAE

This brief is submitted by the

amici states pursuant to Supreme Court Rule 36.4.

By the McCarran-Ferguson Act, 15 U.S.C. § 1011, et seq., Congress re-established the states' right under their police powers to regulate the business of insurance. The Court has recognized the great public interest which the states have in regulating insurance and their commensurate authority: "[T]he power of the state is broad enough to take over the whole business, leaving no part for private enterprise." California Auto. Assn. v. Maloney, 341 U.S. 105, 110 (1951).

Pursuant to this authority, the amici states have regulated the business of health insurance by mandating policy

provisions, particularly in group policies. 1/ For example, the State of Connecticut mandates that the following

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1/ See generally Brummond, Federal Preemption of State Insurance Regulation Under ERISA, 62 Iowa L.Rev. 57 (1976); Manno, ERISA Preemption and the McCarran-Ferguson Act: The Need for Congressional Action, 52 Temp. L. Q. 51 (1979); Okin, Preemption of State Insurance Regulation by ERISA, 13 Forum 652 (1978); Rottman, Rawls, and Gollaher, National Association of Insurance Commissioners Statement on Federal Preemption of State Insurance Regulation under Section 514 of ERISA, 1 NAIC Proceedings 1977, 237 (July 21, 1976).

Amici states of Connecticut, Kansas, Maine, Maryland, Minnesota, Montana, New York, North Dakota, Virginia, and Wisconsin have mandated benefit statutes requiring that benefits be provided for mental health treatment. Conn. Gen. Stat. § 38-174d; K.S.A. 40-2,105; 24A M.R.S.A. § 2843 (Supp. 1983-84); Md. Ann. Code Art. 48A, § 477E (Michie Supp. 1984); Minn. Stat. Ann. § 62A.152 (West Supp. 1934); Mont. Code Ann. §§ 33-22-701 to 704 (1983); N.Y. Insur. Law 162 (16); N.D. Cent. Code § 26-39-03 to -04 (1978); Va. Code § 38.1-348.7 (1981); Wis. Stat. Ann. § 632.89 (West 1980 and Supp. 1983-84).

provisions be included in group health policies: Conn. Gen. Stat. §§ 38-174d (minimum mental illness benefits), 38-174e (non-termination of coverage for mentally retarded or physically handicapped dependent children), 38-174g (minimum newborn benefits), 38- 174h (certain payments to dentists), 38-174i (minimum drug overdose benefits), 38-174j (prohibition of offsets based on disability benefits), 38-174k (minimum home health care benefits), 38-1741 (minimum home health care benefits provided by a recognized nonmedical system), 38-174m (minimum loss ratio in medicare supplement policies), 38-174n (lien on workers' compensation awards), 38-174o (standards for third party prescription programs), 38-174p (offer of coverage for comprehensive rehabilitation services), 38-174q

(minimum occupational therapy benefits), 38-262b (minimum alcoholism treatment benefits), 38-262c (standards for cancellation or discontinuance of coverage), 38-262d (conversion and extension rights), 38-262f (offer of coverage for outpatient treatment of alcoholism), 38-262g (limitation on spousal premium charges), 38-262h (spousal coverage as employee and dependent), 38-262i (minimum benefits for treatment of tumors and leukemia), 38-262j (prohibition against age discrimination) and Conn. Gen. Stat., Chapter 692 (minimum benefits and policy provisions for group Comprehensive Health Care Plans).

Although the statute before the Court, Massachusetts General Laws, Chapter 175, § 47B (Section 47B),

pertains only to mandatory minimum mental health benefits, a holding of preemption under § 514(a) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C § 1144(a), would remove many other benefits and protections provided in group health insurance policies enjoyed by the citizens of various states and throw them into what some commentators have referred to as "the regulatory void." 2/ Moreover, Appellants' arguments of preemption under ERISA and the National Labor Relations Act, 29 U.S.C. § 151 et

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2/ Brummond, supra, at 117-20; Rottman, supra, at 291-97. Additionally, a holding of preemption would place both the industry and the state regulators in the difficult position of ascertaining

Continued on next page.

seq., (NLRA), if adopted by the Court, would seriously erode, if not eliminate, state supremacy in the regulation and control of the health insurance business. Thus, the amici states have substantial interests in the proper resolution of the questions presented in these appeals.

Amici states file this brief in support of the Commonwealth of Massachusetts urging that the judgment of the Supreme Judicial Court of the Commonwealth of Massachusetts be affirmed.

Footnote 2 continued:

whether the purchaser of a group health insurance policy is a qualified employee benefit plan under 29 U.S.C. §§ 1002(1) and 1003(a) to determine whether state insurance law applies to the policy. Donovan v. Dillingham, 688 F.2d 1367 (11th Cir. 1982), provides insight into some of the difficulties in determining whether an ERISA-qualified employee benefit plan does exist.

SUMMARY OF ARGUMENT

A statute of the Commonwealth of Massachusetts mandating that insurance companies provide minimum mental health benefits in general insurance policies which may be purchased by employee benefit plans does not relate to employee benefit plans within the meaning of 29 U.S.C. § 1144(a) as construed in Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504 (1981), and Shaw v. Delta Air Lines, Inc., _____U.S._____, 103 S.Ct. 2890 (1983).

Even if it were to be found that such a statute relates to employee benefit plans, it would be saved from preemption under the terms of ERISA's savings clause, 29 U.S.C. § 1144(b)(2)(A). This is the only result consonant with the McCarran-Ferguson Act

and ERISA, 29 U.S.C. § 1144(d), and is necessary to avoid rendering the savings clause and the deemer clause, 29 U.S.C. § 1144(b)(2)(B) surplusage.

Preemption under the National Labor Relations Act is based on two doctrines, the first preempting state regulation concerning conduct arguably protected or prohibited by the NLRA and the second preempting state regulation of conduct intended by Congress to be unregulated. The latter doctrine, which governs this case, is restricted to state regulation affecting the balance of power in collective bargaining negotiations and requires a substantial effect on such balance of power. The Massachusetts statute does not affect the balance of power in negotiations and does not have a substantial effect on the negotiation of terms of agreements

in view of its tangential relation as health legislation to the collective bargaining process and its tolerance of the alternative of providing benefits without insurance.

The doctrine governing this case recognizes also a balancing of the state interest in regulation against the potential interference with the federal interest. The state interest in health underlying the Massachusetts statute outweighs the limited effect on negotiation of terms of agreements.

Furthermore, the statute is not preempted since Congress intended to allow state regulation of insurance under the McCarran-Ferguson Act. The provision of the McCarran-Ferguson Act for application of the NLRA to the business of insurance refers only to the labor relations of insurance companies.

ARGUMENT

I.

A STATUTE OF THE COMMONWEALTH OF MASSACHUSETTS MANDATING THAT INSURANCE COMPANIES PROVIDE MINIMUM MENTAL HEALTH BENEFITS IN GENERAL HEALTH INSURANCE POLICIES WHICH MAY BE SOLD TO EMPLOYEE BENEFIT PLANS ESTABLISHED PURSUANT TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, 29 U.S.C. § 1001 ET SEQ., IS NOT PREEMPTED BY 29 U.S.C. § 1144(a)

The Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1144(a), provides in part: "Except as provided in subsection (b) of this section, the provisions of this subchapter...shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan...." The noted exception to this preemption clause, 29 U.S.C. § 1144(b)(2)(A), is a broad savings clause for certain state laws and reads as follows: "Except as provided in

subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."

The subparagraph (B) exception to this savings clause protects only employee benefit plans and their trusts by providing that they shall not be deemed, inter alia, to be an "insurance company or other insurer...or to be engaged in the business of insurance...for purposes of any law of any State purporting to regulate insurance companies, [or] insurance contracts...."

Finally, Congress clearly indicated its intent that ERISA was to have no effect on any existing federal legislation by the following language in 29 U.S.C. § 1144(d):

> Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(b) of this title) or any rule or regulation issued under any such law.

Thus, in order to hold that a state statute mandating that insurance companies provide specific health benefits in general insurance policies is preempted by ERISA, the Court must first find that the statute "relates to" employee benefit plans for the purposes of the general preemption clause, 29 U.S.C. § 1144(a). If a determination is made that the statute relates to employee welfare benefit plans, and a further finding is made that the statute does not regulate insurance within the savings clause, 29 U.S.C. § 1144(b) (2)(A), only then will the state law be held to be preempted.

A. The Statute Does Not Relate To Employee Benefit Plans

In order to come within the ambit of ERISA preemption, a state law must "relate to" an employee benefit plan.

In Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 524 (1981), a New Jersey workers' compensation statute banning pension benefit offsets based on workers' compensation was held to relate to employee benefit plans within the meaning of 29 U.S.C. § 1144(a). Having found that ERISA permitted all employee benefit plans to make pension benefit offsets based on workers' compensation, the Court concluded that the "relate to" requirement was met since the New Jersey statute directly deprived employee benefit plans of a "calculation technique" permissible under federal law. Id. at 524-25.

In Shaw v. Delta Air Lines, Inc., ____U.S.____, 103 S.Ct. 2890, 2900 (1983), the Court held that the New York Human Rights Law related to employee benefit plans to the extent that it prohibited practices (providing discriminatory benefits) permitted by federal law and that, similarly, the New York Disability Benefits Law related to employee benefit plans insofar as it required employers offering the plans to provide specific disability benefits.

All three state statutes under consideration in Alessi and Shaw did "relate to" employee benefit plans because they applied directly to the plans and gave the plans no choice but to significantly change or alter the benefits payable under the plans. In the present case, however, the state

statute applies only to insurance companies issuing general health insurance policies which may or may not be purchased by employee benefit plans. The plans clearly are not forced to comply with these laws, but may elect to become self-insurers.

That the state statute at issue here, Section 47B, applies only to group insurance policies and not employee benefit plans, is evidenced by the fact that the action was brought only against insurance carriers who issue the affected policies and not against employers or employee organizations who

offer employee benefit plans or the plans themselves. 3/

To hold that a state statute applicable only to insurance companies issuing general health insurance policies relates to employee benefit plans and is therefore within the

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3/ Indeed, the insurance carriers who raise the issue of preemption under 29 U.S.C. § 1144(a) in this action would appear to lack the requisite standing under ERISA, 29 U.S.C. § 1132(a), had they attempted to bring suit in their own right to enforce the preemption provision of ERISA. Blue Cross and Blue Shield of Kansas City v. Bell, No. 84-2255 (D. Kan., Nov. 7, 1984) (citing Tuvia Convalescent Center, Inc. v. National Union of Hospital and Health Care Employees, 717 F.2d 726 (2d Cir. 1983); Pressroom Union-Printers League Income Security Fund v. Continental Assurance Co., 700 F.2d 889 (2d Cir.), cert. denied, 104 S.Ct. 148 (1983)).

preemptive ambit of ERISA, 29 U.S.C. § 1144(a), would be an unwarranted extension of the holdings in Alessi and Shaw, and would make any state law which regulates or affects a product which an employee benefit plan may purchase or an activity in which an employee plan may engage susceptible to a claim of ERISA preemption.

B. The Statute Is Expressly Excepted From ERISA Preemption by 29 U.S.C. § 1144(b)(2)(A)

Expressly excepted from the general preemption provided in 29 U.S.C. § 1144(a) is "any law of any State which regulates insurance...." 29 U.S.C. § 1144(b)(2)(A). A state statute which mandates minimum benefits in general health insurance policies sold by insurance companies is a law which regulates insurance. Such a statute

directly regulates the relationship between the insurer and the insured and has been considered to be at the center of insurance regulation by this Court:

> The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement-- these were the core of the 'business of insurance.' Undoubtedly, other activities of insurance companies relate so closely to their status as reliable insurers that they too must be placed in the same class. But whatever the exact scope of the statutory term, it is clear where the focus was-- it was on the relationship between the insurance company and the policyholder. Statutes aimed at protecting or regulating this relationship, directly or indirectly, are laws regulating the 'business of insurance.'

S.E.C. v. National Securities, 393 U.S. 453, 460 (1969).

Several factors dictate that state mandatory benefit statutes were intended by Congress to come within the savings clause exception, 29 U.S.C. § 1144(b)(2)(A), to the general preemption provision of ERISA. First, the exception is written in the broadest language possible: "any law of any State which regulates insurance...." (Emphasis added). It has been noted that this savings clause exception to the general rule of preemption was so broad as to envelop the general rule and made it necessary to include the deemer clause exception, 29 U.S.C. § 1144(b)(2)(B), to the savings clause to prevent the direct application of state insurance laws

to employee benefit plans and, in effect, require them to become insurance companies. 4/ The deemer clause would be surplusage if Congress did not consider the savings clause exception to be extremely broad.

Since the direct application of state insurance laws to employee benefit plans is prevented by the deemer clause, the savings clause must be construed to encompass insurance laws which indirectly affect employee benefit plans, or it, too, would be rendered surplusage. Wadsworth v. Whaland, 562 F.2d 70, 78 (1st Cir. 1977), cert. denied, 435 U.S. 980 (1978).

4/ Kilberg and Inman, Preemption of State Law Under ERISA: Drawing the Line Between Laws That Do and Laws that Do Not Relate to Employee Benefit Plans, 19 Forum 162, 163 (1983).

In 1979, Congress failed to enact an amendment to ERISA that would have taken state mandatory minimum coverages in insurance out of the protection of the broad exception for insurance laws. The report of the Senate Committee on Labor and Human Resources specifically stated that the proposed amendment was intended to legislatively overrule the decision of the First Circuit in Wadsworth v. Whaland, supra. The language proposed in Senate Bill 209 read as follows:

> A State insurance law which provides that a specific benefit or benefits must be provided or made available by a contract or policy of insurance issued to an employee benefit plan is a law which relates to an employee benefit plan within the meaning of subsection (a) and is not a law which regulates insurance within the meaning of subparagraph (A)...

The ERISA Improvements Act of 1979: Summary and Analysis of Consideration, United States Senate Committee on Labor and Human Resources, 1979, pp. 46, 88; see also, 125 Congressional Record 931, 937 (1979).

It is a fundamental canon of statutory construction that an act of Congress should be construed "in such a manner as to give effect to all its parts and to avoid a construction which would render a provision surplusage." Wadsworth v. Whaland, supra, 562 F.2d at 78, citing McDonald v. Thompson, 305 U.S. 263 (1938). Any other construction of these sections of 29 U.S.C. § 1144 would render either the savings or the deemer clause, or both, surplusage. If Congress had intended to preempt any law which may have an effect on employee benefit plans, both the savings clause

and the deemer clause would have been unnecessary.

All these subsections of 29 U.S.C. § 1144 underscore and reinforce the long-standing Congressional policy of state supremacy in the regulation of the insurance business set forth in the McCarran-Ferguson Act, 15 U.S.C. §§ 1011 and 1012. 5/

5/ 15 U.S.C. § 1011 reads:

> Congress declares that the continued regulation and taxation by the several states of the business of insurance is in the public interest, and that silence on the part of Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.

15 U.S.C. § 1012 reads in pertinent part:

Continued on next page.

The general preemptive clause, 29 U.S.C. § 1144(a), is silent as to the business of insurance and can hardly be construed to relate specifically to the business of insurance. The savings clause, 29 U.S.C. § 1144(b)(2)(A), specifically refers to insurance, but only to reinforce the non-preemptive mandate of 15 U.S.C. § 1012(b). Finally, the language of 29 U.S.C. § 1144(d) clearly indicates Congressional intent that nothing in ERISA is to be construed to alter the status quo of other federal legislation.

Footnote 5 continued:

> (a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

Continued on next page.

Thus, a fundamental canon of statutory construction, the McCarran-Ferguson Act, and the language of 29 U.S.C. § 1144(d) of ERISA, lead to the conclusion that ERISA does not preempt a state insurance statute directly applicable to insurance companies and the terms of the policies they issue.

Footnote 5 continued:

> (b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance....

II.

THE MASSACHUSETTS STATUTE IS NOT PREEMPTED BY THE NATIONAL LABOR RELATIONS ACT

A. The Massachusetts Statute Lacks a Substantial Effect On Negotiation Of An Agreement And The Balance Of Power In Collective Bargaining

1. Preemption Requires a Substantial Effect On Negotiation of an Agreement and the Balance of Power in Collective Bargaining

This Court has recognized two distinct approaches to preemption of state regulation by the National Labor Relations Act. The first approach preempts state regulation concerning conduct that is arguably prohibited or protected by the Act. San Diego Building Trades Council v. Garmon, 359 U.S. 236, 245 (1959). The second approach prohibits state regulation having a substantial effect on conduct

that Congress intended to be unregulated, specifically conduct involving the self-help remedies left to the parties in labor disputes. Lodge 76, International Association of Machinists v. Wisconsin Employment Relations Commission, 427 U.S. 132, 140, 147-148 (1976). The existence of these two doctrines of NLRA preemption has been confirmed by the Court on several occasions. Belknap, Inc. v. Hale, ___ U.S._____, 103 S.Ct. 3172, 3176-77 (1983); New York Telephone Co. v. New York State Department of Labor, 440 U.S. 519, 527-531 (1979); Lodge 76, International Association of Machinists v. Wisconsin Employment Relations Commission, supra, 427 U.S. at 138-140.

In Belknap, Inc. v. Hale, supra, _____U.S._____, 103 S.Ct. at

3177-81, the Court's application of the Machinists doctrine recognizes the more limited preemption under that doctrine than under Garmon. The Court requires a determination of actual effect of the state regulation on conduct intended by Congress to be unregulated. By contrast, Garmon requires only a showing of state regulation of conduct arguably protected or prohibited by the Act. There is no requirement under Garmon of establishing the practical effects of the state regulation on that conduct.

This distinction between Garmon and Machinists is clearly indicated by the Court in Belknap. Its application of Garmon is premised on state regulation of conduct arguably protected or prohibited by the Act. Id. at ___, 103 S.Ct. at 3181-82. Its application of

Machinists, however, undertakes careful inquiry into the degree of effect of the state regulation on conduct that Congress intended to be unregulated.

The Court's application of Machinists in Belknap is marked by its focus on the tangential relation of suits for damages by replacements to the federal recognition of the employer's rights with respect to hiring replacements during a strike. The Court regards the infliction of injury on third parties as tangential to the rights of employer and union to use economic weapons against each other. Id. at ____, 103 S.Ct. at 3177-78. The Court further rejects the argument of serious detriment to the employer from the conditioning of offers to the replacements in order to avoid a breach

of contract, should the employer be ordered to reinstate strikers or should a settlement require reinstatement. Id. at ___, 103 S.Ct. at 3178-79. The Court then undertakes a calculation of the effects of the state regulation on federal rights. The Court discerns no substantial impact on settlement of strikes since the employer can condition offers to replacements to avoid suits for damages. Id. at ___, 103 S.Ct. at 3180-81. The employer's risk of liability upon discharge of replacements under a settlement is viewed as minimal. The Court recognizes no greater effect on settlement than under preemption of suits for damages.

The critical aspect of the Court's approach is its reliance on calculating the degree of effect of the

state regulation on conduct intended by Congress to be unregulated. This reliance is illustrated by the Court's comparison of the effects on federal rights with and without preemption, its emphasis on the lack of substantial impact on settlement and the minimal risk of employer liability and its recognition of the tangential relation of suits for damages to federal rights. The Court does not accept, as it does under Garmon, an approach under Machinists which requires only a conclusion that the state regulation concerns conduct in an area covered by the NLRA.

In addition to the requirement of substantial effect on conduct intended by Congress to be unregulated, the Machinists doctrine requires upsetting

the balance of power between employer and union in bargaining. This is clearly the focus in Belknap. Id. at ___, 103 S.Ct. at 3177. Machinists, too, was decided on the basis of the effects of the state law on the balance of economic weapons between union and employer. Lodge 76, International Association of Machinists v. Wisconsin Employment Relations Commission, supra, 427 U.S. at 148-151. In New York Telephone Co. v. New York State Department of Labor, supra, 440 U.S. at 531-533, the Court was again concerned with the effect on the balance of economic weapons between employer and union.

With respect to the intent of Congress to leave unregulated the terms of collective bargaining agreements, the Machinists doctrine must be construed as limited to state regulation affecting

the balance of power in the negotiation of the terms of such agreements. Local 24, International Brotherhood of Teamsters v. Oliver, 358 U.S. 283, 293-294 (1959). This also follows from the Congressional concern with the balance of power in leaving unregulated the terms of agreement. In H.K. Porter Co., Inc. v. NLRB, 397 U.S. 99 (1970), the Court indicated the underlying rationale for leaving unregulated the terms of agreements. "It is implicit in the entire structure of the Act that the Board acts to oversee and referee the process of collective bargaining, leaving the results of the contest to the bargaining strengths of the parties." Id. at 107-108.

Accordingly, the Machinists doctrine requires a substantial effect on conduct intended by Congress to be

unregulated and state regulation affecting the balance of power in negotiation of terms of agreements.

2. The Massachusetts Statute Lacks a Substantial Effect On Conduct Intended by Congress to be Unregulated

a. The Massachusetts Statute Lacks a Substantial Effect on Negotiation of an Agreement

The Court's approach in Belknap leads to the conclusion that Section 47B is not preempted by the NLRA. The tangential relation of the statute to the concerns of Congress in leaving unregulated the terms of agreement must be considered. It cannot seriously be argued that Congress had in mind the preemption of health and welfare legislation totally unrelated to regulation of collective bargaining when it sought to leave the parties free to enter into terms of agreement. Moreover,

preemption here would lead to the absurd result of preempting major pieces of critical state health and safety legislation with similar tangential effects on collective bargaining agreements. For example, state legislation on automobile seat belts and prescription drugs would be preempted.

The effects of Section 47B on collective bargaining agreements are further limited by the ability of the parties to reach agreements without the use of insurance. Employee health plans may be provided without the purchase of insurance. The statute applies only when the parties have purchased insurance.

b. The Massachusetts Statute Does Not Affect the Balance of Power in Collective Bargaining

Section 47B does not affect the Congressional concern with the balance of power in leaving unregulated the terms of agreements, since it allows the parties to negotiate benefits without purchasing insurance and, even when insurance is purchased, equally restrains each party in bargaining for other benefits.

B. The Balancing Test Between State and Federal Interests Requires a Holding Against Preemption

1. The Test for Preemption Requires a Balancing of the State Interest in Regulation Against the Potential for Interference With the Federal Interest

The Machinists doctrine is subject to the exceptions under the Garmon doctrine, which have been incorporated, under Farmer v. United Brotherhood of Carpenters & Joiners of America, Local

25, 430 U.S. 290, 297-301, 304 (1977), in a test balancing the state interest in regulation against the potential for interference with federal regulation. These include the exceptions for state regulation involving deeply rooted local interests, matters of peripheral concern to the NLRA and health and safety. Id. at 296-297, 301 n. 10, 299, 302-303. The Court in Machinists indicates that its doctrine is limited by the same exceptions as is Garmon. Lodge 76, International Association of Machinists v. Wisconsin Employment Relations Commission, supra, 427 U.S. at 151. The Court's acceptance of the Garmon exceptions for purposes of the Machinists doctrine is further revealed by its reference to basic exceptions to preemption of general applicability including the exceptions for deeply rooted

local interests and matters of peripheral concern to the NLRA. Id. at 136-137.

In New York Telephone Co. v. New York State Department of Labor, supra, 440 U.S. at 533-534, the plurality accepts under Farmer a distinct state regulatory purpose as an exception to preemption. It decides against preemption on the basis of the purpose of unemployment compensation statutes to provide a state program of employment security rather than the purpose to adjust bargaining power as well as Congressional intent in federal unemployment compensation statutes to allow state regulation. Id. at 533-537. The concurring opinion also recognizes the applicability of the Garmon exceptions to the Machinists doctrine such

as the exception for deeply rooted local interests. Id. at 550.

2. The State Interest in Health Under the Massachusetts Statute Outweighs Its Limited Effect on the Federal Policy of Leaving Unregulated the Terms of Agreements

Application of the Farmer balancing test to Section 47B requires a holding against preemption. The purpose of the state statute is to promote the health of citizens, not to regulate labor relations. It falls not only within the Farmer balancing test as a separate state interest but also within the specific exceptions for deeply rooted local interests in light of the state interest in the health of its citizens and for health and safety regulations.

The potential for interference in federal interests under the NLRA is limited. First, the statute, unlike the New York statute in New York Telephone Co., does not affect the balance of power between the parties in bargaining. It permits the parties to negotiate benefits without the purchase of insurance and, even when insurance is purchased, affects the terms of the collective bargaining agreement with an equal impact on union and employer. Furthermore, Section 47B as health legislation has a tangential relation to regulation of the collective bargaining process, and preemption here would have the absurd consequence of preempting critical state health and safety legislation.

Accordingly, the state's interest in the health of its citizens outweighs the potential interference with the federal policy, and the Massachusetts statute is thus not preempted by the NLRA.

C. The McCarran-Ferguson Act Establishes a Congressional Intent to Allow the Massachusetts Statute

Section 47B is not preempted by virtue of the McCarran-Ferguson Act. The Act provides in relevant part: "No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance." 15 U.S.C. § 1012(b). Section 47B directly regulates insurance and insurance policies, and therefore the NLRA does not invalidate such regulation.

Attorney General v. Travelers Insurance Co., 385 Mass. 598, 613-614, 433 N.E.2d 1223, 1232 (1982). The Massachusetts statute is therefore distinguishable from the New York arbitration statute in Hamilton Life Insurance Co. v. Republic National Life Insurance Co., 408 F.2d 606, 611 (2d Cir. 1969).

McCarran-Ferguson is not rendered inapplicable on the basis of Section 4 of the Act, which provides: "Nothing contained in this chapter shall be construed to affect in any manner the application to the business of insurance o...the National Labor Relations Act, or...the Fair Labor Standards Act...." 15 U.S.C. § 1014. This must be interpreted to mean that the labor relations of insurance companies are subject to the NLRA. Section 4 of McCarran-Ferguson provides for the application to

the business of insurance of the Fair Labor Standards Act. 15 U.S.C. § 1014. If this provision were construed to refer to application of the NLRA to state regulation of insurance, as opposed to the state regulation of the labor relations of insurance companies, then similarly it must be construed to refer to the application of the Fair Labor Standards Act to the state regulation of insurance, as opposed to state regulation of minimal standards of employment at insurance companies. However, the Fair Labor Standards Act, 29 U.S.C. § 201 et seq., by its very nature is concerned with the minimum wages and maximum hours in employment and therefore could have no application to state regulation of insurance. Accordingly, 15 U.S.C. § 1014 must refer to the application of the Fair Labor Standards Act to employment

standards of insurance companies and, similarly, to the application of the NLRA to labor relations of insurance companies.

This interpretation is also supported by the recognition that 15 U.S.C. § 1014 is not an exception to 15 U.S.C. § 1012(b) but merely states that nothing in the chapter affects the applicaton of the NLRA to the business of insurance. Accordingly, 15 U.S.C. § 1014 does not impose a limitation on the authorization of state regulation of insurance in 15 U.S.C. § 1012(b) but merely clarifies the irrelevance of that provision to the labor relations of insurance companies. In essence, 15 U.S.C. § 1014 confirms that the phrase "business of insurance" as used in 15 U.S.C. § 1012(b) may not be interpreted as including the labor relations of insurance companies.

CONCLUSION

For the foregoing reasons, the judgment of Supreme Judicial Court of the Commonwealth of Massachusetts should be affirmed.

RESPECTFULLY SUBMITTED,

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BRIEF

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

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Appellant,

v.

COMMONWEALTH OF MASSACHUSETTS,
Appellee.

On Appeal from the Supreme Judicial Court for the Commonwealth of Massachusetts

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INTEREST OF AMICI CURIAE

The American Psychiatric Association, founded in 1844, is the nation's largest organization of qualified doctors of medicine specializing in psychiatry. More than 30,000 of the approximately 37,000 psychiatrists in the United States are APA members. The APA has participated as amicus curiae in numerous cases involving mental health issues, including *Connecticut v. Heckler*, No. 83-2136, *Ake v. Oklahoma*, No. 83-5424, *Barefoot v. Estelle*, 103 S. Ct. 3383 (1983), *Youngberg v. Romeo*, 457 U.S. 307 (1982), *Mills v. Rogers*, 457 U.S. 291 (1981),

Estelle v. Smith, 451 U.S. 454 (1981), *Parham v. J. R.*, 442 U.S. 584 (1979), *Addington v. Texas*, 441 U.S. 418 (1979), and *O'Connor v. Donaldson*, 422 U.S. 563 (1975).

The National Association of Private Psychiatric Hospitals is the nation's largest organization of hospitals devoted primarily to the treatment of mental illness. Founded in 1933, the Association has over 200 member-hospitals located throughout the United States. Membership in the Association is limited to facilities that have been accredited as psychiatric hospitals by the Joint Commission on the Accreditation of Hospitals. Last term the Association participated as amicus curiae in *Jefferson Parish Hospital District No. 2 v. Hyde*, 104 S.Ct. 1551 (1984).

The American Academy of Child Psychiatry is a national professional association of over 3,000 physicians who have completed a general psychiatric residency and two years of additional fellowship training in child psychiatry. Founded in 1953, the Academy, through a network of regional councils and a national consortium of mental health organizations, works closely with government agencies and mental health professionals in a variety of settings to improve the quality and delivery of mental health treatment to children and their families.

Amici are intensely interested in the outcome of this case. As organizations of providers of psychiatric care, amici believe that states must have authority to regulate the content of health insurance policies to assure that policyholders and their families receive adequate levels of coverage for mental illness. In this brief, we argue that ERISA's preemption and savings clauses should be interpreted consistently with the McCarran-Ferguson Act. Under well-defined McCarran-Ferguson principles, state mandated benefit laws are within the core of the

"business of insurance" whose regulation Congress reserved to the states. We further show that mandated benefit laws are a highly appropriate form of government regulation necessary to correct for serious distortions in the insurance market.[1]

INTRODUCTION AND SUMMARY OF ARGUMENT

This case concerns the authority of the states, consistent with ERISA, to regulate the content of health insurance policies to assure that they provide adequate levels of health coverage. The insurance industry, seeking displacement of all such regulation, focuses on the preemption provision in ERISA, and attempts to emasculate the insurance savings clause of that same statute. Massachusetts, by contrast, argues that the ERISA "savings clause" gives it complete authority to regulate employee health insurance plans so long as its laws relate to insurance generally. We believe that the savings clause, while more limited in scope than suggested by the Commonwealth, preserves a zone of permissible state regulation that includes, at its core, the type of mandated benefit laws at issue here.

ERISA's legislative history sheds little light on the insurance savings clause itself. Although the policies behind the general preemption provision are clear, those policies cannot be extended to a savings clause that, by its terms, is designed to place certain categories of state regulation—including, specifically, regulation of insurance—beyond the reach of ERISA preemption. In our view, the essence of the savings clause can best be gleaned from the McCarran-Ferguson Act, where Congress set forth definitively its view of the appropriate role of the states in regulating "the business of insurance." There is no reason to believe that the regulatory

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[1] The parties have consented to the filing of this brief. Their letters of consent have been lodged with the Clerk.

authority ceded to the states in McCarran-Ferguson was meant to be taken back in ERISA. On the contrary, juxtaposition of these two statutes suggests that, in preserving state regulation of insurance in ERISA, Congress had the McCarran-Ferguson Act very much in mind.

Under established McCarran Ferguson principles, mandated benefit laws are clearly within the "business of insurance" whose regulation Congress left to the states. These laws operate to spread the risk of loss; they directly affect the relationship between the insurer and its policyholders; and their impact is confined to entities within the insurance industry. *See, e.g., Union Labor Life Insurance v. Pireno*, 102 S. Ct. 3002 (1982). Interpreting ERISA consistently with McCarran-Ferguson thus reserves to the states the authority they need to assure that insurance policies do not leave policyholders and their families exposed to staggering financial losses for necessary medical treatment. This does not mean, however, that insurers may be subject to any type of state regulation that applies generally to insurers or that purports to regulate insurance.

Many states, for example, have enacted mandated provider laws that require insurers to make payments to particular categories of health practitioners. For all the reasons that mandated benefit laws regulate the "business of insurance" within the meaning of McCarran-Ferguson, these provider statutes do not. *See Group Life & Health Insurance Co. v. Royal Drug*, 440 U.S. 205 (1979). Although this case directly involves only mandated benefit laws, it is important for the Court to realize that a reasonable interpretation of the savings clause need not transform that provision into an exception that consumes the rule of ERISA preemption.

Interpreting ERISA's savings clause consistently with the McCarran-Ferguson Act makes far more sense than

the analysis advanced by appellant. Metropolitan's expansive reading of ERISA's preemption provision is predicated on the argument that mandated benefit laws conflict with Congress' objective of fostering uniformity in employee benefit plans. However, any alleged "disuniformities" created by mandated benefit laws are no different in kind or degree from disuniformities that may be created by various types of state regulation of insurance—for example, regulation of insurers' reserves and premiums—that appellant concedes are not preempted by ERISA. With respect to alleged disuniformities between insured and self-funded plans, moreover, Congress reasonably could have preserved state regulation of the former, while entrusting to market forces the regulation of the latter. Because of union representation and other factors, businesses large enough to self-insure are likely to provide adequate health insurance without government regulation.

Contrary to appellant's claims, mandated benefit laws represent a highly desirable form of government regulation necessary to correct distortions in the insurance market that effectively prevent the underwriting of significant health risks. In this regard, insurance protection for mental illness is a classic case of "market failure." As a result of incomplete information concerning the risks of mental illness; the threat of "adverse selection" confronting any individual insurer wishing to provide adequate coverage; and the existence of state-funded mental health facilities as a safety net for the underinsured, private insurers do not provide acceptable levels of coverage for mental illness in an unregulated environment. It is implausible to suggest that Congress intended to prohibit the states from addressing this problem when it enacted ERISA.

ARGUMENT

I. STATE MANDATED BENEFIT LAWS ARE WITHIN THE CORE OF PERMISSIBLE REGULATION OF INSURANCE RESERVED TO THE STATES THROUGH ERISA'S "SAVINGS CLAUSE"

The permissible role of the states in the regulation of health insurance plans turns on the interpretation of ERISA's "savings clause," section 514(b)(2)(A), 29 U.S.C. 1144(b)(2)(A). That clause expressly limits ERISA's displacement of state law by "saving" from preemption "any law of any State which regulates *insurance*, banking, or securities." (emphasis added). Although direct regulation of employee benefit plans is precluded by section 514(b)(2)(B) of ERISA, the scope of the savings clause is otherwise complete and unqualified. On its face, section 514(b)(2)(A) preserves intact "any" state law of general applicability "which regulates insurance."

The Massachusetts statute at issue in this case, section 47B of Massachusetts General Laws Chapter 175, is plainly a state law regulating insurance. Nonetheless, it is argued here that the Massachusetts statute is preempted because the savings clause of ERISA means a great deal less than it says. Focusing on ERISA's preemption provision, section 514(a), rather than on the savings clause, section 514(b)(2)(A), appellant contends that the savings clause must be narrowly construed. Appellant reasons that, because of the importance that Congress ascribed to the preemption of state laws in general, Congress must have intended to strictly limit the operation of state regulation of insurance in particular.

In resolving this question, the Court will find little guidance in ERISA's legislative history. The relevant Committee reports, debates and hearings shed virtually no light on Congress' contemporaneous understanding of

how much state regulation of insurance was to be preserved through the savings clause. What the legislative materials do contain, of course, is extensive discussion of the purposes underlying ERISA's basic preemption provision. However, these expressions of Congressional intent, on which appellant's arguments rest, provide no real assistance in determining Congress' intentions with respect to the savings clause.

It is true that section 514(a) of ERISA, preempting all state laws "insofar as they . . . relate to any employee benefit plan," is broad in scope. The provision was intended to displace all state laws that fall within its sphere, *see Alessi v. Raybestos-Manahattan, Inc.*, 451 U.S. 504 (1981), including even state laws that are consistent with ERISA's substantive requirements, see *Shaw v. Delta Airlines Inc.*, 103 S. Ct. 2890 (1983). Nonetheless, the sphere in which section 514(a) operates was explicitly marked off by section 514(b)(2)(B). Congress' intent with respect to the basic preemption provision of ERISA says little, if anything, about the meaning of a savings clause that, by its terms, was intended to limit that provision by placing certain categories of state law—including, specifically, those regulating insurance—beyond its reach. Clearly, one must look elsewhere for evidence of Congressional purpose with respect to the savings clause.

A. ERISA's Savings Clause For Insurance Must Be Read Consistently with the McCarran-Ferguson Act

The McCarran-Ferguson Act, 15 U.S.C. 1011 *et seq.*, vests in the states primary authority for the regulation and taxing of the "business of insurance." The statute provides broadly that "the business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business." 15 U.S.C. 1012(a). The Act further provides for a *de facto* preemption of federal

statutes not dealing specifically with insurance. Section 1012(b) states: "No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business. . ."

McCarran-Ferguson was enacted in 1945 following this Court's decision in *United States v. South-Eastern Underwriters Association*, 322 U.S. 533 (1944). That decision, overturning prior authorities, sustained an indictment of insurance companies under the Sherman Act on grounds that the business of insurance was interstate commerce and, as such, subject to federal regulation under the Commerce Clause. Although most litigation concerning the McCarran-Ferguson Act has focused on its qualified exemption from the antitrust laws, 15 U.S.C. 1013(a) & (b), Congress' "primary concern" in enacting the statute "was to ensure that the States would continue to have the ability to tax and regulate the business of insurance." *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205, 217-18 (1979) (footnote omitted). *See SEC v. National Securities, Inc.*, 393 U.S. 453, 458 (1969); *Prudential Insurance Co. v. Benjamin*, 328 U.S. 408, 429 (1946).

Congress sought to maintain the states' traditional role in the regulation of insurance and to assure that those regulatory activities could be carried out free from federal interference. *SEC v. National Securities, Inc.*, 393 U.S. at 459-61. As the Court has recently explained, "the McCarran-Ferguson Act freed the States to continue to regulate and tax the business of insurance companies, in spite of the Commerce Clause." *Group Life & Health Insurance Co. v. Royal Drug, supra*, 440 U.S. at 218 n.18. The statute "operates to assure that the States are free to regulate insurance companies without fear of Commerce Clause attack." *Ibid.*

The McCarran-Ferguson Act thus represents the definitive expression of Congress' intent to allocate to the states the principal, if not exclusive, responsibility for the regulation of the business of insurance. That responsibility was not to be disturbed by Congress, other than through federal legislation dealing "specifically" with insurance. 15 U.S.C. 1012(b). Nothing in ERISA indicates that Congress intended to effect a wholesale reallocation of this responsibility, relegating the states to a minor role and transfering to the federal government virtually complete authority over the regulation of employee benefits provided through insurance programs.

"Where the field which Congress is said to have preempted has been traditionally occupied by the States . . . 'we start with the assumption that the historic police powers of the states were not to be superseded by the Federal Act unless that was the clear and manifest purpose of the Congress.'" *Jones v. Rath Packing Co.*, 430 U.S. 519 (1977), quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947). This is particularly true where the field of state law is one that has been occupied by the states, not merely as a matter of tradition, but as a consequence of another act of Congress expressly ceding that authority to them. At issue here is not simply the displacement of state law, but the displacement of *federal* law as well.

What Congress gave to the states in the McCarran-Ferguson Act, Congress obviously could have taken away in ERISA. It should not be assumed that Congress did this *sub silentio*, however. Congress was certainly aware of the McCarran-Ferguson Act when it enacted ERISA; and Congress was certainly familiar with the Act's broad guarantee of state primacy in the regulation of insurance. Indeed, juxtaposition of the relevant portions of ERISA and McCarran-Ferguson suggests that Congress may have had McCarran-Ferguson very much in mind when drafting ERISA's savings clause for insurance.

Section 514(d) of ERISA provides that ERISA's preemption provision may not be construed to "alter, amend, modify, invalidate, impair, or supersede any law of the United States . . ." 29 U.S.C. 1144(d). While this savings clause is sufficient to preserve virtually any other federal statute, the McCarran-Ferguson Act poses a unique difficulty because of its own exemption for any federal law that "specifically relates to the business of insurance." 15 U.S.C. 1012(b). Because it is at least arguable that ERISA is a law that "relates to the business of insurance," some further clause in ERISA was needed to assure that McCarran-Ferguson would not be partially repealed by section 514(a). By making clear that section 514(a) does not extend to state laws regulating insurance, section 514(b)(2)(A) serves precisely this purpose.

This construction of the insurance savings clause is reinforced by ERISA's "deemer" provision, section 514(b)(2)(B). Although that provision qualifies the savings clause by forbidding direct state regulation of employee benefit plans, it does so by tracking the language of the McCarran-Ferguson Act. The provision clarifies that employee benefit plans are not to be regarded as, *inter alia*, the "business of insurance." The "business of insurance," of course, is the operative term of McCarran-Ferguson. *See* 15 U.S.C. 1012(a) & (b). As this Court has emphasized, the McCarran-Ferguson Act does not apply to the activities of insurers generally or to the insurance industry as such. *Group Life & Health Insurance Co. v. Royal Drug Co.*, *supra*, 440 U.S. at 217, 220; *SEC v. National Securities, Inc.*, *supra*, 393 U.S. at 459-60. Rather, it applies more narrowly to specific economic arrangements constituting "the business of insurance."

Even if section 514(b)(2)(A) does not, by its terms, effectuate the McCarran-Ferguson Act's proscriptions in this area, the savings clause should still be read consistently with the policies of McCarran-Ferguson. *See Wadsworth v. Whaland*, 562 F.2d 70, 78 & nn.41, 42 (1st Cir. 1977), *cert. denied*, 455 U.S. 980 (1978); *Insurance Commissioner v. Metropolitan Life Insurance*, 463 A.2d 793, 796 (Md. 1983); *Metropolitan Life Insurance v. Whaland*, 410 A.2d 635, 640 (N.H. 1979). In the absence of some clear indication to the contrary, it must be assumed that Congress intended to maintain state primacy in the regulation of insurance, including health insurance.

B. State Mandated Benefit Laws Are Clearly Regulations of The "Business Of Insurance" Within The Meaning Of The McCarran-Ferguson Act

Interpreting the insurance savings clause consistently with the McCarran-Ferguson Act does not transform section 514(b)(2)(A) into an exception that consumes the rule of preemption under section 514(a). Although the McCarran-Ferguson Act is broadly worded, decisions of this Court have narrowly defined the "business of insurance" to which it applies. Still, state mandated benefit laws are within the core of this definition and are therefore saved from preemption under section 514(b)(2)(A) of ERISA.

In *Group Life & Health Insurance Co. v. Royal Drug Co.*, *supra*, the Court was presented with the question whether agreements between an insurer and certain pharmacies constituted the "business of insurance" within the meaning of McCarran-Ferguson. Under the agreements, selected pharmacies undertook to sell prescription drugs to policyholders at a fixed mark-up over the pharmacies' costs. Policyholders using the participating pharmacies paid only the amount of the mark-up (a constant charge of $2 for each prescription), with the balance being billed directly to the insurer. Although policyholders were free to use other pharmacies, the insurer discouraged them from doing so through a combination of economic and administrative disincentives.[2]

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[2] Coverage under the policies was more limited in these circumstances. Also, the insured had to first pay for the prescription in full, and then submit a claim to the insurer for reimbursement.

In rejecting the McCarran-Ferguson Act claim, the Court held that the challenged arrangements were not the "business of insurance," even though they involved insurance and were entered into by an insurer regulated by state law. The Court reasoned that the arrangements did not operate to spread risk—an "indispensible characteristic of insurance." 440 U.S. at 212. Because the insurer was already obligated to pay the covered drug benefits, the agreements with the pharmacies served only to minimize the insurer's costs. In this respect, they did not "involve any underwriting or spreading of risks, but [were] merely arrangements for the purchase of goods and services." *Id.* at 214.

The Court's conclusion was confirmed by the absence of other factors characteristic of the "business of insurance." In enacting McCarran-Ferguson, Congress was concerned with the relationship between insurers and their policyholders. *Id.* at 216-17. *See SEC v. National Securities, Inc., supra*, 393 U.S. at 460. Yet the agreements with the pharmacies defined the insurer's relationship, not with its insureds, but with providers of covered health services. 440 U.S. at 217. The Court further noted that state regulation subject to the McCarran-Ferguson Act typically applies only to entities that are within the insurance industry. 440 U.S. at 231. While the participating pharmacies were engaged in business with an insurer, they were not themselves insurers or a part of the insurance industry. *Ibid.*

Likewise, in *Union Labor Life Insurance Co. v. Pireno*, 102 S. Ct. 3002 (1982), the Court applied the same definition of the "business of insurance" to reject an insurer's claim that its use of peer review practices was exempt from antitrust challenge under the McCarran-Ferguson Act. The insurer's use of peer review did not operate to spread or underwrite risk, the Court held; the risk of loss for medically necessary treatment had already been shifted to the insurer through its policies. Moreover, the insurer's peer review practices were conducted, not by the insurer itself, but by an independent group of health care providers. Thus, the insurer's use of peer review was neither integral to the relationship between the insurer and its policyholders, *id.* at 3009, nor limited in its application to entities within the insurance industry, *id.* at 3010.

Application of these principles demonstrates that mandated benefit laws like Massachusetts' section 47B are within the core of state regulation of the "business of insurance" under the McCarran-Ferguson Act. First, and most importantly, state statutes requiring coverage for specified illnesses or disorders obviously operate to spread the risk of loss—indeed, that is their sole purpose. By mandating the provision of health benefits that otherwise would be provided at a lower level or not provided at all, mandated benefit statutes shift the risk of loss for medically necessary treatment from the individual insured to the insurer.

In addition, it is clear that mandated benefit laws directly regulate the relationship between the insurer and its policyholders. By requiring coverage for certain disorders, such laws prescribe key terms of that relationship. And finally, there can be no question that the impact of mandated benefit laws is confined to entities within the insurance industry. Although third parties may be indirectly affected by such statutes, mandated benefit laws regulate only insurers, not providers or other entities outside of the insurance industry.

This analysis would apply not only to state laws mandating coverage for mental illness, but to other mandated benefit laws as well. For example, a state statute requiring insurers to include coverage for sickle cell anemia, *see, e.g.*, Ala. Code tit. 27 § 5-13, chronic kidney disease, *see, e.g.*, Ohio Rev. Code Ann. § 392.25 (Baldwin), treatment for mastectomies, *see, e.g.*, N.H. Rev. Stat. Ann. § 1713:27-46.1a, birth defects, *see, e.g.*, Oregon Rev. Stat.

§ 743.119, or complications in pregnancy, *see, e.g.*, Idaho Code § 41-2140, would also constitute the "business of insurance" within the meaning of the McCarran-Ferguson Act.[3] As such, they too would be saved from preemption under ERISA pursuant to section 514(b)(2)(A).

To say that mandated benefit laws are saved from preemption under ERISA, however, is not to say that all state laws regulating insurers would be similarly preserved under the savings clause. Even state statutes purporting to regulate certain aspects of the content of health insurance policies would not constitute the "business of insurance" if they did not satisfy the criteria for exemption under McCarran-Ferguson. Thus, for example, many state statutes require that insurers make payments to particular types of health providers. These statutes do not require the insurer to cover a particular medical condition. Rather, they require insurers to provide payment to specified classes of health practitioners *if* those practitioners treat a condition already covered under the insurance policy.[4]

It is clear that laws of this type could not be construed as state regulations of the "business of insurance" since the mandated practices have nothing to do with the

[3] As of 1984, the statutes of 26 states mandated insurance coverage for one or more specified illnesses or procedures. These states were: Alabama, Arizona, California, Colorado, Connecticut, Idaho, Illinois, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New York, North Dakota, Ohio, Oregon, Rhode Island, Virginia, Washington, and Wisconsin. *See* Amicus Brief of Health Insurance Association of America in Support of Jurisdictional Statements at 1a-16a.

[4] Twenty-six states currently have such "mandated provider" laws. These laws require that insurers make payment to a broad range of health providers, including chiropractors, podiatrists, psychologists, optometrists and nurse midwives. *See* Amicus Brief of Health Insurance Association of America in Support of Jurisdictional Statements at 5a-16a.

spreading or underwriting of risk. By requiring that insurers provide reimbursement for the services of specified practitioners, these statutes do not shift the risk of loss from policyholders to the insurer. As in the case of the pharmacy agreements in *Group Life & Health Insurance Co. v. Royal Drug Co., supra*, and the peer review procedures in *Union Labor Life Insurance Co. v. Pireno, supra*, the insurer is already obligated to pay for such losses up to the limits of its policies. Mandated provider laws simply regulate the relationship between the insurer and certain categories of providers—parties wholly outside the insurance industry.[5]

In sum, interpreting ERISA's savings clause as incorporating the McCarran-Ferguson Act's exemption for the "business of insurance" demarcates a permissible zone of state insurance regulation that is both narrowly circumscribed and well-defined. Under this approach, laws relating to insurance are not saved from preemption simply because they purport to regulate insurers or insurance policies. The permissible zone of state regulation is thus more limited than would be the case under appellee's interpretation of section 514(b)(2)(B). At the same time, this approach would not impose on the states the straitjacket proposed by appellant. As we now show, appellant's analysis of ERISA's savings clause does not withstand scrutiny.

[5] For this reason virtually every court that has considered the question has concluded that the McCarran-Ferguson Act does not extend to decisions of insurers to restrict the range of health providers entitled to receive direct payment for covered health services. *See Klamath-Lake Pharmacy v. Klamath Medical Services Bureau*, 701 F.2d 1276 (9th Cir.), *cert. denied*, 104 S. Ct. 88 (1983); *Hahn v. Oregon Physicians' Service*, 689 F.2d 840 (9th Cir. 1982), *cert. denied*, 103 S. Ct. 3115 (1983); *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, 624 F.2d 476 (4th Cir. 1980), *cert. denied* 450 U.S. 916 (1981); *Trident Neuro-Imaging Laboratory v. Blue Cross and Blue Shield of South Carolina*, 568 F.Supp. 1474 (D.S.C. 1983).

C. Application of McCarran-Ferguson Act Principles Makes Far More Sense Than Appellant's Approach

Appellant's interpretation of ERISA's savings clause is predicated, not on Congressional intent with respect to that clause, but on the purposes and policies underlying the basic preemption provision of ERISA, section 514(a). We have already pointed out that Congressional intent with respect to section 514(a) is of little usefulness in interpreting a savings clause which, by its terms, is intended to limit the reach of the preemption provision. However, even if the purposes behind section 514(a) were a guide to the interpretation of the savings clause, they do not lead to the conclusion that appellant wishes the Court to reach.

Metropolitan stresses that one of Congress' main objectives in providing for the preemption of state law in ERISA was to foster uniformity in the design of employee benefit plans. This much is clearly correct. *See Shaw v. Delta Airlines Inc., supra*, 103 S. Ct. at 2903. Appellant argues that state mandated benefit laws are inconsistent with this objective in two respects. First, they create "disuniformity" in the insured plans of multistate employers who must comply with the potentially divergent mandated benefit laws of different states. Second, appellant argues that, because ERISA's "deemer" provision precludes direct state regulation of employee benefit plans, mandated benefit laws create disuniformity between regulated and self-insured plans within the same state.

Under appellant's theory, all mandated benefit laws are preempted by section 514(a). At the same time, however, Metropolitan concedes—as it must—that ERISA does *not* preempt certain other types of state regulation of insurance that are designed to protect policyholders and to ensure the solvency of insurers. State laws of this type constitute regulation of the "business of insurance" within the meaning of the McCarran-Ferguson Act. *See*

SEC v. National Securities Inc., supra, 393 U.S. at 459-61. They include, according to appellant, state laws prescribing the level of reserves that insurers must maintain and state laws regulating insurers' premium rates. Brief of Metropolitan Life Insurance Co. at 34-35.

Appellant's argument proves too much. Whatever the extent of these disuniformities—and we believe that they are exaggerated [6]—it is evident that the potential for significant disuniformities is already created by the "traditional" forms of state regulation that appellant acknowledges are saved from preemption. For example, depending on the degree of variation among states, regulation of insurance premiums may require multistate employers to provide very different types and levels of coverage for employees in different states. The provision of uniform coverage in such circumstances would force employees in the low premium states to subsidize the coverage of employees in the high premium states.

The same is obviously true with respect to state regulations governing insurers' reserves. Insurance reserve accounts—which are held against future claims—are funded by the excess of premiums collected over actual claims paid (plus the insurer's costs and profit). The level of reserves required by state regulations plainly has a direct bearing on a plan's premium rates and benefits. A multistate employer doing business in states prescribing different reserve requirements cannot efficiently provide the same insurance policy for all employees. Premium levels and coverage (or both) will vary, unless employees in the states prescribing low reserve require-

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[6] It is significant that at trial appellant made little effort to prove the extent of any costs attributable to the disuniformities. See Brief of Appellee Opposing Jurisdictional Statements at 5-6. In its merits brief to this Court, Metropolitan is careful to claim only that "[a]t trial, defendants *stressed* that mandated benefit statutes" create costly disuniformities among plans. Brief of Metropolitan Life Insurance Co. at 6 (emphasis added).

ments subsidize employees in the states requiring higher reserves.

These same concededly *permissible* regulations of insurance also have the potential for creating substantial disuniformities between plans within the same state. Because of ERISA's "deemer" provision forbidding direct state regulation of employee benefit plans, section 514 (b)(2)(B), state regulations pertaining to premium rates or reserve requirements cannot be applied to self-insured plans. Metropolitan repeatedly argues that Congress could not have intended the preservation of assertedly burdensome state regulation that encourages employers to self-insure. Under appellant's own theory, however, states will continue to have the regulatory authority to create precisely this incentive.[7]

Whether these other types of disuniformity are a good or bad thing is not the point here. All we mean to say is that substantial disuniformities may be created by the very types of state regulation that appellant acknowledges are *not* preempted by ERISA. It follows that any disuniformities that might be created by state mandated benefit laws *cannot* be a sufficient basis for concluding that those laws are preempted by section 514(a).

Moreover, it is extremely unlikely that, in enacting ERISA, Congress intended to create a regulatory vacuum as complete as that urged by appellant. Although ERISA

[7] A further source of disuniformity between insured and self-insured plans is created by state premium taxes applied to commercial health insurers in most states. See J. Meyer, "Health Care Competition: Are Tax Incentives Enough?" in *A New Approach to the Economics of Health Care* 424 (1981). It has been estimated that these taxes can effectively increase an insurer's costs (relative to an exempt nonprofit or self-insured plan) by as much as 20 to 30 per cent. H. Frech, "Blue Cross, Blue Shield and Health Care Costs: A Review of the Economic Evidence" in *National Health Insurance: What Now? What Later? What Never* 250, 251-52 (1980).

applies substantive requirements to pension and retirement plans, no such standards are imposed on health insurance policies; only the statute's fiduciary and reporting requirements apply to employee benefit plans. ERISA §§ 201(1), 301(a)(1), 29 U.S.C. §§ 1051(1), 1081(a)(1). *See* Hutchinson & Ifshin, *Federal Preemption of State Law Under the Employee Retirement Income Security Act of 1974*, 46 Chicago L. Rev. 23, 30 (1978). Because no other federal laws regulate the content of insurance policies, appellant's theory yields the result that health insurance policies are simply exempt from any regulation of their substantive content.

If Metropolitan's theory prevails, there will be nothing to prevent insurers from offering wholly inadequate health coverage in group insurance policies. *See generally*, K. Davis, *National Health Insurance: Benefits Costs and Consequences* 34-41 (Brookings, 1975). Insurers would be free to curtail or eliminate catastrophic protection, leaving policyholders without coverage after the first few days of extended hospitalization. Policyholders could discover that, because of hidden exclusions, "preexisting condition" limitations, coinsurance requirements or other restrictions, their policies do not provide the coverage they thought they had.

It may be argued that this is not a valid concern because the ordinary functioning of the market for health insurance—a market that is admittedly competitive in many respects—will assure that such abuses do not occur. This argument, however, overlooks the fact that, by and large, the purchasers of group health insurance policies are not individual policyholders acting in their own self-interest, but employers. While most employers can be expected to act as proxies for their employees, it cannot be assumed that all will. Undoubtedly, some employers will purchase inadequate insurance as a means of minimizing costs.

Seen in this light, ERISA's disparate treatment of self-funded employee benefit plans and insured plans is not anomalous at all. While preserving state regulation of the content of insured plans, Congress entrusted to market forces the regulation of self-funded plans. It is reasonable to think that the need for regulation is much greater for the former than for the latter. Because of union representation and other factors,[8] businesses large enough to self-insure are likely to provide adequate health insurance without government regulation. Businesses too small to self-insure, by contrast, are likely to have a freer hand in the design of insurance coverage for their employees.[9]

In sum, there is no merit to appellant's analysis of ERISA's savings clause. ERISA plainly contemplates disuniformities among employee benefit plans as well as disparate treatment of self-funded and insured plans. What ERISA clearly does *not* contemplate is the creation of a regulatory void in which no jurisdiction—state or federal—oversees the content of health insurance policies to assure that policyholders are not faced with devastating losses due to inadequate coverage.

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[8] Self-insured companies that are not unionized frequently have avoided unionization because they offer favorable employee benefits, including health insurance policies. Companies of that size are also more likely to have skilled workers who are not readily replaceable in the event of disabling illness. Such businesses may calculate that, by reducing illness-related productivity losses, comprehensive health insurance is a good investment.

[9] This generalization has been borne out in the mental health field. A 1983 study of employers in major industries concluded that self-insured plans were more likely than insured plans to provide mental health coverage comparable to that provided for physical illness. S. Muszynski, J. Brady & S. Sharfstein, *Coverage for Nervous and Mental Disorders: Summaries of 300 Private Sector Health Plans* 16-17 (1983).

II. MANDATED BENEFIT LAWS ARE NECESSARY TO CORRECT FOR "MARKET FAILURE" IN THE MARKET FOR HEALTH INSURANCE

Appellant characterizes mandated benefit laws as dispensable economic legislation that, by altering the health coverage that would be offered in an unregulated environment, serve no valid purpose. The argument is simply wrong. As we show, mandated benefit laws represent a highly desirable form of government intervention necessary to correct for "market failure" in the market for health insurance.

We start with two propositions. The first is that the states have a strong interest in assuring that their citizens have minimally adequate health insurance. Because of the high cost of medical care, underinsured persons suffering catastrophic illness may face staggering financial losses. Few families have the means to absorb such costs, with the result that many patients afflicted with serious illness requiring extended treatment may be unable to obtain it. To the extent such persons can find free or subsidized care, they impose substantial economic burdens on private and public health facilities. *See* Congressional Budget Office, *Catastrophic Medical Expenses: Patterns in the Non-Elderly, Nonpoor Population* (1982). Mandated benefit laws protect against these dislocations by requiring insurers to provide adequate protection.

The second proposition is that insurance providing substantially less coverage than that required by mandated benefit laws will produce precisely these types of dislocations. For example, several states require coverage for complications in pregnancy, *see, e.g.*, Cal. Ins. Code § 10119.5 (West), and birth defects, *see, e.g.*, Oregon Rev. Stat. § 743.119. Insurance not providing such coverage would expose insureds to thousands of dollars in unreimbursed medical bills. The same is true with respect to state laws mandating coverage for mastectomies, *see, e.g.*, N.H. Rev. Stat. Ann. § 1713:27-46.1a,

sickle cell anemia, Ala. Code tit. 27 § 5-13, or reconstructive surgery, *see, e.g.*, Minn. Stat Ann. § 62A.25 (West). In the case of mental illness, patients requiring hospitalization for only twenty or thirty days beyond the coverage limits of their policies would face bankrupting costs.[10]

The risk that insurers will provide inadequate levels of health protection in the absence of government regulation is particularly great with respect to mental health treatment. This is so because insurers' decisions about whether to offer such coverage, and consumers' decisions about whether to purchase it, are seriously skewed by distortions in the market for health insurance that prevent the underwriting of significant health risks. As explained below, the market for health insurance covering mental illness is a classic case of market failure for which government intervention in the form of mandated benefit laws is plainly appropriate.[11]

A. Lack of Information

Market failure in this area derives from several distortions. The first, and most important, is a lack of information in the hands of consumers concerning the risks

[10] Long-term hospitalization is not uncommon in the treatment of acute mental illness. In 1975, 34 percent of all persons admitted to private psychiatric hospitals were hospitalized for more than 29 days. *See* National Institute of Mental, *Characteristics of Admissions to Selected Mental Health Facilities, 1975, Mental Health Service System Reports No. 2* (1981). Hospitalizations are longest in the case of childhood psychiatric disorders. In 1975 the *median* stay in a private psychiatric hospital for such treatment was 40.6 days. *Ibid.*

[11] This is not to say that every mandated benefit law covering mental illness necessarily prescribes an appropriate level of coverage. Because *de jure* minimums often become *de facto* maximums, the coverage requirements of such statutes should be set to fully correct for market distortions.

of severe mental illness requiring costly and extensive treatment. T. McGuire, *Financing Psychotherapy: Costs, Effects and Public Policy* at 61 (1981). Responding to market forces, an insurer provides the types and levels of health coverage that consumers want, based on their perceptions of the risks associated with particular medical conditions. In the case of mental illness, most purchasers of health insurance, whether individuals or employers, seriously underestimate the risks involved. Believing—erroneously—that the risk of mental disease is far below that of physical illness, they undervalue mental health coverage in the market.

In fact, the incidence of severe mental illness, such as manic depression, schizophrenia, and other psychotic disorders, is generally comparable to the incidence of cancers and heart disease—medical conditions for which complete insurance coverage is usually thought to be indispensable. In 1980 the number of admissions to hospitals throughout the United States for treatment of mental disorders was approximately 1.69 million, or 75.9 admissions for every 10,000 persons. Department of Health and Human Services, *Utilization of Short-Stay Hospitals: Annual Summary for the United States, 1980, National Health Survey Series 13* at 34-35 (March 1982). The incidence of cancer and heart disease were of the same order of magnitude. For malignant neoplasms of all types, the number of hospital admissions was 1.82 million, or 82 admissions per 10,000 population. For all types of heart disease, hospital admissions totalled 3.2 million. *Ibid.*

The prevalence of severe mental illness is even more striking when specific mental disorders are compared with specific forms of physical illness. For instance, the number of hospitalizations in 1980 for the treatment of psychotic illnesses was 507,000. *Ibid.* Comparable figures for selected physical conditions were as follows: acute myocardial infarction, 431,000; congestive heart failure, 401,000; ulcers of the stomach and small intes-

tine, 363,000; and infectious diseases, 649,000. *Ibid.* For the treatment of all types of leukemia, there were 53,000 hospital admissions in the United States in 1979. Department of Health and Human Services, *Detailed Diagnoses and Surgical Procedures for Patients Discharged from Short-Stay Hospitals, 1979* at 16, 307 (January 1982). The risks of severe mental illness are thus fully comparable to those of physical illnesses for which adequate insurance is universally available.

The widespread misapprehension of the risks of mental illness is perhaps best illustrated by statistics pertaining to suicide among adolescents. In 1980, 5381 children and teenagers died from suicide—the third leading cause of death for persons in this age group. *See* Department of Health and Human Services, *Data From the National Center for Health Statistics*, 30 Monthly Vital Statistics Report 21 (December 20, 1982). Although precise figures are not available, it can be assumed that many more adolescents, suffering from depression or other serious illnesses, made unsuccessful suicide attempts.[12] By contrast, the number of hospitalizations for acute lymphoid leukemia, the type of leukemia that strikes mainly children, was approximately 9,000 in 1979. Department of Health and Human Services, *Detailed Diagnoses and Surgical Procedures for Patients Discharged from Short-Stay Hospitals, 1979* at 307 (January 1982). Most families would find unacceptable an insurance policy that offered little or no coverage for this type of cancer. Yet, because of incomplete information, the same consumers undervalue psychiatric coverage for their children.

The market distortion of incomplete information concerning the risks of mental illness is compounded by the

[12] Medical experts generally assume that the number of unsuccessful suicide attempts are fifty to a hundred times greater than the number of completed suicides. See M. McIntire, C. Angle & M. Schlicht, "Suicide and Self-Poisoning in Pediatrics," 24 Advances in Pediatrics 291 (1977).

stigma that many people associate with mental illness. S. Sharfstein, S. Muszynski & E. Myers, *Health Insurance and Psychiatric Care: Update and Appraisal* 52 (1984). Even persons who are aware of the general risks of mental disease may discount those risks with respect to themselves or their families. *See* Brown, "The Life of Psychiatry," 133 Journal of American Psychiatry 489 (1976). Because of the moral opprobrium that society continues to attach to psychiatric illness, many consumers are unwilling to acknowledge the fact that mental illness, like physical illness, can strike randomly; they believe the statistical probabilities apply only to others.

For these reasons, insurers as a group are unlikely to offer adequate levels of mental health coverage in an unregulated environment. Responding to market forces, most insurers will not offer coverage that consumers do not demand, irrespective of the magnitude of the health risks that go uncovered. Moreover, a second distortion in the health insurance market reinforces this problem by assuring that, once the pattern of inadequate coverage is established, no single insurer can deviate from it. This second market distortion is known as "adverse selection."

B. Adverse Selection

All health insurance plans spread the risk of loss due to illness by having substantially more "good risk" subscribers than "bad risk" subscribers. As the term suggests, adverse selection occurs when a particular plan is selected by a disproportionate number of bad risks. To pay the increased claims generated by these bad risk subscribers, the plan must raise its premium rates to all subscribers. This causes some good risks to leave the plan to obtain lower cost coverage elsewhere. Their departure, in turn, forces the plan to raise premiums still higher, thus causing more of the good risk subscribers to leave the plan. *See* A. Donabedian, *Benefits in Medical Care Programs* 354-58 (1970); T. McGuire, *Financing Psy-*

chotherapy: Costs, Effects, Public Policy, supra, at 44-51. If unchecked, the spiraling effect of adverse selection can destroy an insurance plan.

Adverse selection makes the market failure for mental health insurance complete by preventing any individual insurer from breaking ranks with its competitors to offer adequate coverage. Even an insurer that recognizes the need for this coverage, and wishes to offer it, would quickly conclude that the risks were prohibitive. It would calculate that, by increasing coverage in this area, the plan's costs would go up as existing bad risk subscribers use the coverage and new bad risks migrate to the plan. The premium rate increases necessary to cover these costs would then drive good risks out of the plan to competing insurers able to offer more favorable premiums.[13]

The threat of adverse selection is not confined to mental health coverage. A disproportionate number of subscribers who are bad risks with respect to heart disease, cancer or other illness will similarly cause good risks to leave an insurance plan. However, the exodus of good risks from a plan that is adversely selected on the basis of its mental health coverage will be accelerated by the fact that mental health coverage is an insurance benefit that most good risks do not want. As discussed earlier,

[13] This scenario is not merely hypothetical. In 1973 one of the insurance plans offered to federal employees as part of the Federal Employees Health Benefits Program unilaterally raised its coverage for mental illness. Because of an influx of bad risk subscribers and a loss of good risks, the plan was forced to rescind these benefit increases. *See* McGuire, *supra,* at 49-50. Adverse selection in mental health coverage afflicted a second plan in the federal program in the early 1980s, causing it too to make major reductions in benefits. *See* S. Sharfstein & C. Taube, "Reduction in Insurance for Mental Disorders: Adverse Selection, Moral Hazard and Consumer Demand," 139 American Journal of Psychiatry 1425, 1426-27 (1982).

such persons underestimate the risk of mental illness for themselves and their families and, as a result, undervalue mental health coverage in their selection of insurance.

C. The "Free Rider" Problem

A third type of market failure preventing the underwriting of the risk of mental illness is created by state-operated and state-funded facilities and programs for the mentally ill. These facilities and programs, which include state mental hospitals, community mental health centers, nursing homes and other day and outpatient treatment programs, provide care that is either free or heavily subsidized. The very existence of this system distorts the insurance market by diminishing the value of coverage for mental illness. Why purchase insurance coverage for mental illness (or pay the full price for it) when the state will provide treatment for free? Even if the state-provided care is of lesser quality, its availability reduces the utility of private insurance in the eyes of employers and policyholders.

State mental health systems thus create a classic "free rider" problem. The states have a legitimate interest in limiting the use of these facilities to patients too poor to afford insurance for the treatment of mental illness. Other than through the regulation of insurers, however, states have no mechanism for enforcing this limitation. As the health care provider of last resort, the state must provide medical treatment to patients who need it and have no means to pay for it. This situation is exploited by insurers and insureds who, by underinsuring for mental illness, shift the cost of necessary medical treatment to the state-supported health care system.[14]

[14] This problem is especially acute for the states because Medicare and Medicaid, the principal health insurance programs funded by the federal government, provide only limited coverage for mental illness.

The market for insurance covering mental illness is thus seriously distorted by three types of market failure—lack of information concerning the risks of mental disease, adverse selection, and the "free rider" effect of state-operated and funded health programs. Any one of these distortions creates an unacceptable risk that the insurance market will consistently misallocate health protection in this area—that is, that insurers will not underwrite risks of loss for which the alternative of self-insurance is not possible. The combination of these three types of market failure virtually guarantees that this will be the case. In the absence of regulation, insurers operating in a competitive environment will not offer adequate levels of coverage for severe mental illness.

Mandated benefit laws attempt to correct these market failures by requiring insurers to offer acceptable levels of health coverage. It is no objection to these statutes that they override the decisions of employers about the amount and type of insurance to provide. Brief of Metropolitan Life Insurance Co. at 27-31. That argument misses the point. Where the "choices" made by the market are seriously distorted by market failure, there is no reason to validate those distortions under the guise of preserving "free choice."

From both an economic and social standpoint, it is hard to imagine a more compelling case for government regulation than the market for health insurance covering mental illness. State authority to mandate acceptable levels of coverage in this area should not be disturbed.

CONCLUSION

The judgment of the Massachusetts Supreme Judicial Court should be affirmed.

Respectfully submitted,

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

METROPOLITAN LIFE INSURANCE COMPANY,
Appellant,

v.

COMMONWEALTH OF MASSACHUSETTS,
Appellee.

TRAVELERS INSURANCE COMPANY,
Appellant,

v.

COMMONWEALTH OF MASSACHUSETTS,
Appellee.

On Appeal from the Supreme Judicial Court for the Commonwealth of Massachusetts

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BRIEF FOR THE AMERICAN PSYCHOLOGICAL ASSOCIATION, THE ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOLOGY, AND THE MASSACHUSETTS PSYCHOLOGICAL ASSOCIATION AS *AMICI CURIAE* IN SUPPORT OF APPELLEE.

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INTEREST OF *AMICI CURIAE*

The American Psychological Association (APA) is a voluntary nonprofit, scientific, and professional organization with more than 60,000 members. It has been the major association of psychologists in the United States since 1892. The APA's purpose, as reflected in its bylaws, is to "advance psychology as a science and profession, and as a means of promoting human welfare."

The Association for the Advancement of Psychology (AAP) is a nonprofit corporation supported by the voluntary contributions of 6,000 psychologists. AAP seeks to inform the three branches of government of the ethical, professional, and scientific views of the psychological community.

The Massachusetts Psychological Association, with over 1650 members, is a state affiliate of the APA. It represents the scientific and professional interests of psychologists within Massachusetts, including psychologists working in academic and professional settings, both in public and private institutions.

Amici file this brief pursuant to Rule 36.2 of the Rules of this Court. The parties have consented to the filing of the brief; their consents have been filed with the Clerk.

INTRODUCTION AND SUMMARY OF ARGUMENT

In 1973, the Massachusetts legislature enacted an insurance statute requiring all group health insurance policies to provide specified coverage for mental health benefits. *See* Mass. Ann. Laws ch. 175, § 47B (Michie/Law. Co-op. 1977) (Section 47B). The Massachusetts Supreme Judicial Court—properly in the view of *amici*—rejected appellants' arguments that this statute is preempted by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001 *et seq.*, and by the National Labor Relations Act (NLRA), 29 U.S.C. § 151 *et seq.*

Although Section 47B arguably relates to employee benefit plans and therefore falls within the scope of ERISA's preemption provision, it is excepted from preemption by ERISA's insurance savings clause, which was meant to preserve the long line of state statutes, includ-

ing Section 47B, that regulate the contents of insurance policies. The one exception to the insurance savings clause, which prohibits States from deeming employee benefit plans to be insurers, does not apply to Section 47B, which regulates only insurance companies.

The decision below is additionally supported by the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.*, which represents Congress' judgment that, as a matter of federal policy, insurance regulation should be performed by the States.

This case does not involve a conflict between Section 47B and ERISA, as appellants would have this Court believe. Rather, any conflict that does exist is between ERISA and the McCarran-Ferguson Act. For this reason, this Court's usual reluctance to weigh conflicting policy considerations is particularly appropriate here.

ARGUMENT

I. ERISA WAS NOT INTENDED TO PREEMPT MANDATED BENEFIT STATUTES.

ERISA's preemption provision, § 514(a), 29 U.S.C. § 1144(a), provides that the Act "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title."

There is no question that the benefit plans at issue here are "employee benefit plans" as defined in 29 U.S.C. § 1003. The only issues are whether Section 47B "relates to" employee benefit plans within the meaning of § 1144, and, if so, whether the statute falls within one of the express exceptions to § 1144.

A. Arguably, the Massachusetts Statute "Relates to" Employee Benefit Plans Governed by ERISA.

In *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981), the Court held that ERISA preempted a state statute prohibiting the reduction of a retiree's pension benefits by the amount of workers' compensation awards

the retiree received subsequent to retirement. After finding that Congress had actually contemplated and approved such an offset of pension benefits, the Court concluded that the statute " 'relate[s] to pension plans' governed by ERISA because it eliminates one method for calculating pension benefits . . . permitted by federal law." *Id.* at 524.

The Court's conclusion was not altered by the fact that the statute "intrudes indirectly, through a workers' compensation law rather than directly, through a statute called 'pension regulation.' " *Id.* at 525. Rather, the Court concluded that "even indirect state action bearing on private pensions may encroach upon the area of exclusive federal concern." *Id.*

Then, in *Shaw v. Delta Air Lines, Inc.*, 103 S. Ct. 2890 (1983), the Court held that the New York Human Rights Law and the State's Disability Benefits Law "related to" pension plans governed by ERISA. The Court reasoned that "[a] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Id.* at 2900. Applying this definition, the Court concluded that "the Human Rights Law, which prohibits employers from structuring their employee benefit plans in a manner that discriminates on the basis of pregnancy, and the Disability Benefits Law, which requires employers to pay employees specific benefits, clearly 'relate to' benefit plans." *Id.*

ERISA does not specify which benefits must be included in employee benefit plans. Accordingly, Section 47B does not conflict with any provision of ERISA so as to "relate to" benefit plans in the sense in which that term was used in *Alessi*. But *Alessi* does suggest that the fact that the mandated benefit statute is nominally an insurance law, rather than a benefits plan law--and therefore bears on benefit plans only indirectly—would not save the Massachusetts statute from preemption under ERISA.[1] And be-

[1] Although Section 47B does require employee benefit plans to provide the mental health benefits specified in the statute, there has

cause Section 47B does require that insurance policies issued to benefit plans provide specified mental health benefits, it arguably "relates to" those employee benefit plans just as the Disability Benefits Law did in *Shaw*.

The Massachusetts statute can, however, be distinguished from the New York laws at issue in *Shaw*. New York's Human Rights Law had been interpreted by the state courts to prohibit *any* employer from maintaining an employee benefit plan that treated pregnancy differently from other nonoccupational disabilities. *See* 103 S. Ct. at 2895. The Disability Benefits Law expressly required *all* employers to provide the same benefits for pregnancy-related disabilities as for any other disability. *See id.* at 2896. The Massachusetts statute, by contrast, requires that mental health benefits be provided to only certain employees—those whose benefit plan is covered by an insurance policy. The statute thus "relates to" only those employee benefit plans, and not to benefit plans generally. Arguably, the statute's indirect relation to only a subset of employee benefit plans governed by ERISA takes it outside the scope of the preemption provision.

Most of the courts that have considered ERISA's effect on mandated benefit statutes have, however, concluded that such statutes do "relate to" employee benefit plans governed by ERISA.[2] Accordingly, although the point is

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been no attempt to enforce Section 47B against employee benefit plans and the Commonwealth apparently concedes that that part of the statute is preempted by ERISA. The Massachusetts Supreme Judicial Court, relying on state law, found that the portion of Section 47B applicable to employee benefit plans was severable from the portion applicable to insurance policies. *See Attorney General v. Travelers Ins. Co.*, 385 Mass. 598, 601, 433 N.E.2d 1223, 1225 (1982), *reprinted in* App. to Juris. Stmts. at 13a, 15a-16a. This state law ruling is binding on this Court; accordingly, the only question before the Court is the effect of ERISA on the portion of Section 47B regulating insurance policies.

[2] *See, e.g., Stone & Webster Engineering Corp. v. Ilsley*, 690 F.2d 323, 329 (2d Cir. 1982), *aff'd mem.*, 103 S. Ct. 3564 (1983); *Standard Oil Co. v. Agsalud*, 633 F.2d 760, 766 (9th Cir. 1980), *aff'd mem.*, 454 U.S. 801 (1981); *Wadsworth v. Whaland*, 562 F.2d 70, 77 (1st Cir. 1977), *cert. denied*, 435 U.S. 980 (1978).

not free from doubt, *amici* will assume here that Section 47B does "relate to" employee benefit plans.

B. The Massachusetts Statute Is a Law Regulating Insurance and Is Therefore Excepted from ERISA's Preemption Provision.

Even if Section 47B "relates to" employee benefit plans within the terms of the ERISA preemption provision, the statute is not preempted if it falls within one of the express exceptions to the reach of the preemption provision. The relevant exception here, the so-called insurance savings clause, is set forth in 29 U.S.C. § 1144(b)(2)(A):

> "Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance . . . ."

This Court's prior decisions are of little assistance in determining whether Section 47B is a law which regulates insurance within the meaning of this savings clause. In both cases, the Court noted that state laws regulating insurance are excepted from ERISA's broad preemption provision.[3] But the insurance savings clause was not at issue in either case, and therefore the Court did not elaborate on the reach of that provision. In fact, the Court made clear in *Alessi* that it was not ruling on the applicability of ERISA's preemption provision in cases such as this. *See* 451 U.S. at 525 n. 21.

Congress' intent in excepting state laws regulating insurance from the scope of the ERISA preemption provision cannot be determined from the language of that statute. Nowhere in ERISA does Congress define the phrase "law . . . which regulates insurance" or give any clue to its meaning. But it should be noted that Congress used very broad language in the insurance savings clause: it preserves "*any* law of *any* State which regulates insurance . . . ." (Emphasis added.)

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[3] *See Shaw v. Delta Air Lines, Inc.*, 103 S. Ct. 2890, 2897 (1983); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 n. 19 (1981).

The legislative history does not address the scope of the insurance savings clause. Until the ERISA bill emerged from confererence, every prior version of the preemption provision had superseded state law only in the specific areas regulated by ERISA. The Conference Committee broadened the preemption provision to include all state laws that relate to pension plans, rather than only those dealing with subjects regulated by ERISA, but the Committee did not comment on the reasons for the change. *See* H.R. Rep. No. 1280, 93d Cong., 2d Sess., *reprinted in* 1974 U.S. Code Cong. & Ad. News 5038, 5162. With respect to the insurance savings clause, the Conference Report merely states: "The preemption provisions of title I are not to exempt any person from any State law that regulates insurance . . . ." *Id.*[4]

Moreover, the Conference Committee's changes were not disclosed until the Conference Reports were filed with Congress fewer than ten days before the statute was passed in August 1974. *See* Brummond, *Federal Preemption of State Insurance Regulation Under ERISA*, 62 Iowa L. Rev. 57, 115-16 (1976). Thus, "the present language of section 514 was inserted by the Conference Committee at a very late hour, after no congressional hearings, and with little explanatory comment . . . ." *Id.* at 116.[5]

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[4] The legislative history of prior versions of the preemption provision is similarly unenlightening. *See, e.g.*, S. Rep. No. 127, 93d Cong., 1st Sess. 35, 47 (1973), *reprinted in* 1974 U.S. Code Cong. & Ad. News 4838, 4871, 4883.

[5] In addition, Congress was preoccupied during this period with the issues arising from President Nixon's resignation on August 9, 1974. *See* 120 Cong. Rec. 29,933 (1974) (remarks of Sen. Javits). "[I]t would be naive to suppose that during this period any serious attention could have been devoted to such matters as the status of an obscure preemption provision in a 250-page federal statute." Brummond, *Federal Preemption of State Insurance Regulation Under ERISA*, 62 Iowa L. Rev. 57, 116 (1976); *see also* Okin, *Preemption of State Insurance Regulation by ERISA*, 13 Forum 652, 678 (1978); Comment, *ERISA Preemption and Indirect Regulation of Employee Welfare Plans Through State Insurance Laws*, 78 Colum. L. Rev. 1536, 1542 & n. 42 (1978) (hereafter cited as *ERISA Preemption* Comment).

The few substantive comments concerning preemption made during the debate on the Conference Reports focused on the scope of § 1144(a), not on the exceptions to preemption like the insurance savings clause. *See ERISA Preemption* Comment, *supra* note 5, at 1542 & n. 42. And the three veiled references that were made to the savings clause during the debate on the Conference Reports are not helpful in ascertaining the intended reach of that clause. *See* 120 Cong. Rec. 29,942 (1974) (remarks of Sen. Javits) (referring merely to "certain exceptions . . ."); *see also id.* at 29,197 (remarks of Rep. Dent); *id.* at 29,933 (remarks of Sen. Williams). There is no indication in ERISA's legislative history that Congress recognized the tension between the preemption provision itself, which preempted any state law relating to employee benefit plans, and the insurance savings clause, which preserved all state laws regulating insurance. Thus, there is absolutely no indication that Congress intended to preempt state statutes such as this one.

The language and legislative history of the insurance savings clause therefore require a presumption that Congress intended to give the clause its ordinary meaning: the Court "must give effect to this plain language unless there is good reason to believe Congress intended the language to have some more restrictive meaning." *Shaw v. Delta Air Lines, Inc.*, 103 S. Ct. at 2900.

Interpreting the insurance savings clause according to its plain meaning indicates clearly that Massachusetts' mandated benefit statute is a law that regulates insurance within the meaning of that clause. Section 47B is contained in the chapter of the state statutes that pertains to insurance. It was proposed by the legislature's Joint Committee on Insurance. It was enacted because the legislature found that "[a] need . . . exists for all people to be safeguarded against the high and sometimes crippling costs of professional mental health care today" and that "in order for the cost to be reasonable, insurance for mental illness must be a mandatory feature on all policies sold in the state." General Court Joint Committee on In-

surance, *Advances in Health Insurance in Massachusetts* 9, 5 (Aug. 1974). And it operates by regulating the contents of insurance policies. Certainly, these factors suggest that Section 47B is a law that regulates insurance.

This conclusion is corroborated by the tradition of state insurance regulations—begun long before ERISA was enacted—that, like Section 47B, govern the contents of insurance policies in an effort to protect the interests of the insured. One commentator has noted that the first mandated benefit legislation was enacted in California in 1949. *See* Peel, *Regulatory Developments in Minimum Standards for Health Insurance Policies*, 13 Forum 680, 682 (1978). Since that time, state legislatures have passed a wide variety of mandated benefit legislation.

In Massachusetts, for example, since at least 1956 all group life insurance policies have been required to guarantee that any insured who leaves the group will remain insured under the policy for a certain period unless he is otherwise entitled to similar benefits. *See* Mass. Ann. Laws ch. 175, § 134(4) (Michie/Law. Co-op. 1977). A similar provision governing group health insurance policies was enacted in 1967. *See id.* § 110D. In 1960, the legislature enacted a statute requiring insurance policies to provide coverage for those hospitalized or receiving treatment in a state soldiers' home. *See id.* § 22. In 1962, the Commonwealth required all health insurance policies that provide for termination of a dependent child's coverage at a specified age to continue coverage if the child is "mentally or physically incapable of earning his own living on the termination date . . . ." *Id.* § 108(2)(a)(3). In 1973, in addition to enacting Seciton 47B, the legislature required all group health insurance policies to provide certain specified benefits for the treatment of alcoholism. *See id.* § 110(H). These are only some of the many provisions in the Massachusetts statutes regulating insurance that have been in existence since ERISA was enacted and that mandate specific insurance benefits.[6]

[6] *See also, e.g.*, MASS. ANN. LAWS ch. 175, § 22 (Michie/Law. Co-op. 1977) (prohibiting certain insurance policy provisions;

Thus, "a myriad of state enactments . . . have provided for years the guidance as to what is and is not permissible in the writing of insurance for employee groups." Manno, *ERISA Preemption and the McCarran-Ferguson Act: The Need for Congressional Action*, 52 Temple L.Q. 51, 56 (1979). *See also* Okin, *supra* note 5, at 656 ("State insurance departments have long exercised jurisdiction over the content of individual and group accident and health policies issued in their state by insurance carriers.").[7]

adopted before 1960); *id.* § 47C (requiring all group health insurance policies to provide coverage for newborn infants and adopted children, including coverage of birth abnormalities; adopted on August 9, 1974); *id.* §§ 113C, 113L (requiring all automobile insurance policies to include certain coverage; adopted in 1968); *id.* § 132(1) (requiring life insurance policies to contain a provision providing that the insured is entitled to a thirty-day grace period within which to pay any premium due after the first year; adopted by 1933); *id.* §§ 132(6), 142 (requiring life insurance policies to include a provision entitling the insured to a loan on the policy at a specified interest rate; adopted by 1943).

[7] California, Florida, Michigan, Missouri, and Virginia enacted legislation between 1968 and 1972 that requires insurers to extend major medical coverage to dependents who are disabled when they reach the age where they would otherwise be terminated from coverage under the terms of the policy. *See Wayne Chemical, Inc. v. Columbus Agency Service Corp.*, 426 F. Supp. 316, 324 n. 8 (N.D. Ind. 1977), *modified on other grounds*, 567 F.2d 692 (7th Cir. 1977); VA. CODE § 38.1-348.1 (1981). In 1971, Wisconsin required group health insurance policies to provide coverage for treatment of alcoholism, *see* WIS. STAT. ANN. § 632.89 (West 1980), and Connecticut required such policies to provide mental health benefits, *see* CONN. GEN. STAT. ANN. § 38-174d (West Supp. 1984). Since 1971, California has required that any group hospital, medical, or surgical policy provide coverage for mentally or physically handicapped dependents of the insured after the dependents reach the age of majority. *See* CAL. INS. CODE § 10277 (West 1972). In 1973, the Virginia legislature passed a statute requiring all plans for furnishing prepaid medical services to pay for services rendered by licensed psychologists, podiatrists, chiropractors, and optometrists. *See* VA. CODE § 38.1-824 (1981). Since 1973, Maryland has required all health insurance policies to provide mental health benefits, *see* MD. ANN. CODE art. 48A, § 477E (1979); Minnesota has required that

When ERISA was enacted, therefore, there was already a long tradition of state regulation of the contents of insurance policies. Congress must have been aware of that fact—especially since at that very time insurance companies and state insurance commissioners were developing policies on mandated benefit statutes.[8] And Congress was obviously aware that some pension plans might purchase insurance because ERISA defines "employee welfare benefit plan" as a plan that provides certain benefits "through the purchase of insurance or otherwise . . . ." 29 U.S.C. § 1002(1). If Congress had intended to end the States' longstanding tradition of regulating the contents of insurance policies, it would likely have limited the insurance savings clause in some fashion. *See Insurance Comm'r v. Metropolitan Life Ins. Co.*, 296 Md. 334, 340, 463 A.2d 793, 796 (1983).[9] The fact that it did not suggests that the insurance savings clause was actually intended to mean what it says and thus to preserve state laws like Section 47B.

The overwhelming majority of courts that have considered this issue have concluded that mandated benefit laws are laws that regulate insurance and thus within the scope of the insurance savings clause.[10]

C. The Massachusetts Statute Does Not Fall Within the Scope of the "Deemer Provision."

Although Section 47B must be considered a state law regulating insurance, it is nonetheless preempted by

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all health insurance policies provide coverage for treatment of alcoholism and drug dependence, *see* MINN. STAT. ANN. § 62A.149 (West Supp. 1984); and Wisconsin has required that every group health policy offer certain coverage for treatment of tuberculosis, *see* WIS. STAT. ANN. § 632.90 (West 1980).

[8] In fact, state mandated benefit statutes were sufficiently common prior to the enactment of ERISA to attract considerable attention by the insurance industry. In late 1971, the Health Insurance Association of America (HIAA), which filed an *amicus* brief in support of appellants' jurisdictional statements, appointed a Task Force on Minimum Standards for Health Insurance Policies. The National Association of Insurance Commissioners (NAIC) began deliberations on minimum standards legislation in late 1972; in December 1973, the NAIC adopted a model mandated benefit statute. In early 1974, the HIAA Task Force then began to develop its recommendations for a model statute and, in May 1974, submitted a draft to the NAIC. *See* Peel, 13 FORUM at 682-86. The *amicus* brief filed by HIAA in this case indicates that the association has a membership of 327 private insurance companies, including both appellants, and that these companies write more than eighty-five percent of the health insurance policies written by private insurance companies in this country. *See* Brief *Amicus Curiae* of Health Insurance Association of America in Support of Jurisdictional Statements at 1. HIAA's Vice President and General Counsel is Joe W. Peel, the author of the article cited above.

[9] In fact, a bill was introduced in 1979 to amend ERISA to provide that state mandated benefit statutes are not preserved by the insurance savings clause. *See* S. 209, 96th Cong., 1st Sess. § 155, 125 CONG. REC. 933, 937 (1979). The bill was intended to overrule the court's decision in *Wadsworth v. Whaland*, 562 F.2d 70 (1st Cir. 1977), *cert. denied*, 435 U.S. 980 (1978). *See* 125 CONG. REC. 947 (1979) (remarks of Sen. Javits). Although the bill was reported to the Senate, it apparently died without ever being debated. *See* SENATE COMM. ON LABOR AND HUMAN RESOURCES, 96TH CONG., LEGISLATIVE CALENDAR 108, 111 (final ed. Jan. 4, 1981).

Admittedly, Congress' failure to pass this bill does not necessarily demonstrate its intent that the insurance savings clause exempt mandated benefit statutes from preemption under ERISA. But this postenactment history does indicate that Congress was at least aware of the courts' interpretation of the insurance savings clause, and "it lends weight to the argument . . ." that the savings clause was intended to except mandated benefit statutes. *North Haven Board of Education v. Bell*, 456 U.S. 512, 534 (1982). Moreover, "the relatively insubstantial interest given [this portion of S. 209] seems particularly significant since Congress has proceeded to amend . . ." ERISA's preemption provision in another respect proposed by S. 209. *Id. Compare* S. 209, 96th Cong., 1st Sess. § 155, 125 CONG. REC. 937 (1979), *with* 29 U.S.C. § 1144(b)(5)(A).

[10] *See, e.g., American Progressive Life & Health Ins. Co. v. Corcoran*, 715 F.2d 784, 787 (2d Cir. 1983); *Wayne Chemical, Inc. v. Columbus Agency Service Corp.*, 567 F.2d 692, 700 (7th Cir. 1977); *Wadsworth v. Whaland*, 562 F.2d at 77; *St. Paul Elec. Workers Welfare Fund v. Markman*, 490 F. Supp. 931, 933 (D. Minn. 1980); *Insurance Comm'r v. Metropolitan Life Ins. Co.*, 296 Md. 334, 344-45, 463 A.2d 793, 798 (1983); *Metropolitan Life Ins. Co. v. Whaland*, 119 N.H. 894, 901-02, 410 A.2d 635, 640 (1979) (per curiam). *But see Michigan United Food & Commercial Workers Unions v. Baerwaldt*, 572 F. Supp. 943 (E.D. Mich. 1983), *appeal docketed*, No. 83-1570 (6th Cir. Aug. 16, 1983).

ERISA if it falls within the scope of the one exception to the insurance savings clause. That exception, the so-called "deemer provision," provides that an employee benefit plan may not "be deemed to be an insurance company or other insurer, . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts . . . ." 29 U.S.C. § 1144(b)(2)(B).

The plain meaning of that provision indicates that it does not apply to the statute in question here. The deemer provision clearly states only that a State may not deem an employee benefit plan to be an insurance company and thereby attempt to apply its insurance laws to the benefit plan.

No legislative history suggests that the deemer provision was intended to mean anything other than what it says. The Report explaining the Conference Committee's amendments to the preemption provision merely restates the language of the deemer provision without clarifying its meaning. *See* H.R. Rep. No. 1280, 93d Cong., 2d Sess., *reprinted in* 1974 U.S. Code Cong. & Ad. News 5038, 5162. And there was no mention of the deemer provision either during the debate on the Conference Report or in prior Committee Reports.

Subsequent legislative history does, however, confirm that the deemer provision should be interpreted according to its plain meaning. An activities report issued in 1977 by the Subcommittee on Labor Standards of the House Committee on Education and Labor explains: "the 'deemed' language was utilized to create an irrebuttable presumption that these [employee benefit] plans are not insurance . . . for purposes of state regulation. . . . The irrebuttable presumption would not be overcome even if an employee benefit plan engages in activities which bring it within the insurance . . . activities generally regulated by a state." H.R. Rep. No. 1785, 94th Cong., 2d Sess. 47 (1977). Thus, the Report makes clear that, even though self-insured employee benefit plans may have some of the characteristics of insurance, the deemer provision prohibits a state from applying its insurance regulations to such benefit plans on the ground that they are engaged in the business of insurance.[11] The Report then goes on to point out that an insurance policy sold to an employee benefit plan *is* subject to state regulation:

> "[C]ertain entrepreneurs have undertaken to market insurance products to employers and employees at large, claiming these products to be ERISA covered plans. . . . The entrepreneur will then argue that his enterprise is an ERISA benefit plan which is protected, under ERISA's preemption provision, from state regulation. . . . [T]hese plans are . . . no more ERISA plans *than is any other insurance policy sold to an employee benefit plan.*
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> "To the extent that such programs fail to meet the definition of an 'employee benefit plan,' *state regulation of them is not preempted by section 514, even though such state action is barred with respect to the plans which purchase these 'products.'*" *Id.* at 48 (emphasis added).

This subsequent history is not conclusive evidence of the deemer provision's meaning, but it does provide evidence of Congress' intent, especially in the absence of contemporaneous legislative history. *See, e.g., North Haven Board of Education v. Bell*, 456 U.S. 512, 535 (1982).

Thus, the courts have interpreted the deemer provision to prohibit States from regulating self-insured employee benefit plans under their insurance laws.[12] But the ma-

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[11] *See, e.g.*, Brummond, *supra* note 5, at 77, 90-91; Manno, *ERISA Preemption and the McCarran-Ferguson Act: The Need for Congressional Action*, 52 TEMPLE L.Q. 51, 59 (1979). Because no self-insured benefit plans are involved here, the Court need not rule on the proper application of the ERISA preemption provision in cases involving self-insured plans—for example, whether the deemer provision prohibits a state from applying its insurance regulations to a self-insured benefit plan if additional factors, aside from the mere fact of self-insurance, indicate that the plan is engaged in the business of insurance. Likewise, the Court need not attempt to define precisely what is a self-insured plan.

[12] *See, e.g., Hewlett-Packard Co. v. Barnes*, 425 F. Supp. 1294, 1300 (N.D. Cal. 1977), *aff'd*, 571 F.2d 502, 504 (9th Cir.) (per

jority of courts have also concluded that the deemer provision does not apply to mandated benefit statutes, like Section 47B, that regulate the contents of insurance policies sold to employee benefit plans.[13]

If the deemer provision is interpreted more broadly to bar state regulation of insurance policies issued to employee benefit plans, it would nullify the insurance savings clause. ERISA preempts all state insurance laws that "relate to" employee benefit plans, unless they are excepted by the savings clause. And the deemer provision prohibits States from directly regulating employee benefit plans. If the deemer provision is also interpreted to preempt all state laws that regulate the contents of insurance policies purchased by benefit plans, no state insurance laws relating to benefit plans would be left for the savings clause to save—rendering the savings clause superfluous, in violation of the well-established principle that legislation should be construed so as to give effect to each part. *See, e.g., McDonald v. Thompson*, 305 U.S. 263, 266 (1938). Thus, the deemer provision cannot be read to preempt Section 47B, and that statute must fall within the scope of the insurance savings clause.

II. THE McCARRAN-FERGUSON ACT WAS INTENDED TO PRESERVE MANDATED BENEFIT STATUTES.

Any doubt about ERISA's effect on mandated benefit statutes is laid to rest by the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.*, which provides in relevant part:

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curiam), *cert. denied*, 439 U.S. 831 (1978); *Russo v. Boland*, 103 Ill. App. 3d 905, 909-10, 431 N.E.2d 1294, 1298 (1982).

[13] *See Wadsworth v. Whaland*, 562 F.2d at 77-78; *McLaughlin v. Connecticut General Life Ins. Co.*, 565 F. Supp. 434, 443-44 (N.D. Cal. 1983); *Eversole v. Metropolitan Life Ins. Co.*, 500 F. Supp. 1162, 1169 (C.D. Cal. 1980); *Cate v. Blue Cross & Blue Shield*, 434 F. Supp. 1187, 1190 & n. 5 (E.D. Tenn. 1977); *Insurance Comm'r v. Metropolitan Life Ins. Co.*, 296 Md. at 344-45, 463 A.2d at 798; *Metropolitan Life Ins. Co. v. Whaland*, 119 N.H. at 902-03, 410 A.2d at 640; *ERISA Preemption* Comment, *supra* note 5, at 1540-41. *But see, e.g., General Split Corp. v. Mitchell*, 523 F. Supp. 427, 430 (E.D. Wis. 1981).

"The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business." *Id.* § 1012(a).

The first paragraph of the Act declares the congressional policy that "the continued regulation and taxation by the States of the business of insurance is in the public interest." *Id.* § 1011. Thus, the Act represents Congress' judgment that, as a matter of *federal* policy, the regulation of insurance should be performed by the States.[14] Congress recognized that the States had traditionally exercised this power[15] and wanted to ensure the preservation of such authority in the States,[16] which, in Congress' view, were best able to undertake such regulation.[17] As this Court noted in *SEC v. Variable Annuity Life Ins. Co. of America*, 359 U.S. 65, 68 (1959), "[w]hen the States speak in the field of 'insurance,' they speak with the authority of a long tradition."

The McCarran-Ferguson Act is helpful in determining the reach of ERISA's preemption provision for two additional, independent reasons. First, the meaning of the McCarran-Ferguson Act's reference to state "laws . . . which relate to the regulation . . . of [the] business [of insurance]," 15 U.S.C. § 1012(a), aids in defining the meaning of the similar phrase, state "law which regu-

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[14] *See, e.g.*, H.R. REP. NO. 143, 79th Cong., 1st Sess. 3, *reprinted in* 1945 U.S. CODE CONG. & AD. NEWS 670, 672; S. REP. NO. 1112, 78th Cong., 2d Sess. 3, 7 (1944); 90 CONG. REC. 6525 (1944) (remarks of Rep. Walter); *SEC v. National Securities, Inc.*, 393 U.S. 453, 458 (1969).

[15] *See, e.g.*, H.R. REP. NO. 143, 79th Cong., 1st Sess. 2, *reprinted in* 1945 U.S. CODE CONG. & AD. NEWS 670, 670-71; S. REP. NO. 1112, 78th Cong., 2d Sess. 2 (1944) (noting that the States "have regulated insurance for over 90 years . . .").

[16] *See, e.g.*, H.R. REP. NO. 873, 78th Cong., 1st Sess. 6 (1943); 89 CONG. REC. 10,659 (1943) (remarks of Rep. Miller).

[17] *See, e.g.*, S. REP. NO. 1112, 78th Cong., 2d Sess. 5, 7 (1944); 90 CONG. REC. 6524 (1944) (remarks of Rep. Walter).

lates insurance," found in the insurance savings clause.[18] Second, the final paragraph of ERISA's preemption provision indicates that Congress expressly intended that ERISA not alter or impair any federal statute, including the McCarran-Ferguson Act. *See* 29 U.S.C. § 1144(d).

A. The Relevant Caselaw Compels the Conclusion that Section 47B Is a Statute that Regulates the Business of Insurance.

This Court's decisions interpreting the McCarran-Ferguson Act have identified three criteria relevant in determining whether a particular practice falls within the Act's reference to the "business of insurance": "*first*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry." *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982) (emphasis in original). Mandated benefit statutes like Section 47B satisfy all three criteria.

The first criterion was set forth in detail in *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 212, 211 (1979), where the Court noted that one "indispensable characteristic of insurance" is "the spreading and underwriting of a policyholder's risk." Section 47B unquestionably relates to the spreading and underwriting of risk. The statute reflects a legislative judgment that the costs of mental health care should be underwritten by health insurance policies and that the risk of costly mental health care should be shared. *See* General Court Joint Committee on Insurance, *Advances in Health Insurance in Massachusetts* 5 (Aug. 1974); Superior Court Findings & Conclusions, *reprinted in* App. to Juris. Stmts. at 36a, 50a-51a. It therefore requires that insurance policies insure against "the risk that policyholders will be unable

[18] *See, e.g., Marks v. United States*, 161 U.S. 297, 302 (1896); *McLaughlin v. Connecticut General Life Ins. Co.*, 565 F. Supp. 434, 443 (N.D. Cal. 1983); *Metropolitan Life Ins. Co. v. Whaland*, 119 N.H. 894, 901, 410 A.2d 635, 639 (1979) (per curiam).

to pay for [the cost of mental health care] during the period of coverage." *Royal Drug*, 440 U.S. at 213. By requiring certain coverage in all insurance policies, Section 47B "defines the scope of risk assumed by the insurer from the insured" and has a direct impact on "the measure of the risk" that is transferred to the insurer. *Pireno*, 458 U.S. at 131, 130.

The second criterion was set forth in detail in *SEC v. National Securities, Inc.*, 393 U.S. 453, 460 (1969), where the Court noted that the McCarran-Ferguson Act "was concerned with the type of state regulation that centers around the contract of insurance . . . . The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement—these were the core of the 'business of insurance.'" Congress' "focus," the Court continued, "was on the relationship between the insurance company and the policyholder. Statutes aimed at protecting or regulating this relationship, directly or indirectly, are laws regulating the 'business of insurance.'" *Id.*

Section 47B clearly falls within the scope of this criterion. The statute "centers around the contract of insurance" by prescribing terms that must be included within that contract, and it determines "the type of policy which [can] be issued." And Section 47B is an attempt by the legislature to "secure the interests of those purchasing insurance policies," *id.*, by requiring that the insurer provide certain safeguards to all policyholders. Unlike *Pireno*, therefore, this case involves a statute that is "an integral part of the policy relationship between the insurer and insured." 458 U.S. at 131.

The third criterion is likewise present in this case. Mandated benefit statutes impose requirements solely on insurers, and their purpose is to affect only the relationship between insurers and their policyholders; they do not "inevitably involve[] third parties wholly outside the insurance industry . . . ." *Id.* at 132.[19]

[19] *See also, e.g., Feinstein v. Nettleship Co.*, 714 F.2d 928, 932 (9th Cir. 1983), *cert. denied*, 104 S. Ct. 2346 (1984) (noting that

Thus, this Court's prior decisions interpreting the scope of the McCarran-Ferguson Act indicate clearly that Section 47B is a law that regulates the business of insurance and is not to be superseded by any federal statute. This conclusion has likewise been reached by the vast majority of courts which have considered the question whether the type of benefits offered by an insurance policy fall within the scope of the McCarran-Ferguson Act. In *Grant v. Erie Ins. Exchange*, 542 F. Supp. 457 (M.D. Pa. 1982), *aff'd mem.*, 716 F.2d 890 (3d Cir.), *cert. denied*, 104 S. Ct. 349 (1983), for example, the plaintiffs challenged the defendant insurance companies' refusal to provide insurance coverage for work loss benefits to persons who died in automobile accidents. Noting that " '[m]atters of . . . extent of coverage . . . go to the very heart of the relationship between the insurance company and the policyholder . . . ,' " the court held that the McCarran-Ferguson Act was applicable in that case. *Id.* at 462 (quoting *McIlhenny v. American Title Ins. Co.*, 418 F. Supp. 364, 369 (E.D. Pa. 1976)).[20]

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the term "entities within the insurance company" includes insurers and insureds).

[20] Likewise, in *Anglin v. Blue Shield*, 693 F.2d 315 (4th Cir. 1982), the plaintiff challenged Blue Shield's refusal to offer him a policy protecting himself and his minor child; Blue Shield would offer such a policy only if it also covered the plaintiff's wife. The court concluded that the McCarran-Ferguson Act was applicable because "[t]he allegations in the plaintiff's complaint are the very essence of the relationship between insurer and policyholder. He has alleged that Blue Cross/Blue Shield has refused to offer the exact coverage that he prefers." *Id.* at 320.

See also, e.g., Perry v. Fidelity Union Life Ins. Co., 606 F.2d 468, 476 (5th Cir. 1979), *cert. denied*, 446 U.S. 987 (1980); *Lowe v. Aarco-American, Inc.*, 536 F.2d 1160, 1162 (7th Cir. 1976); *Addrisi v. Equitable Life Assurance Soc'y of United States*, 503 F.2d 725 (9th Cir. 1974), *cert. denied*, 420 U.S. 929 (1975); *Dawson v. Whaland*, 529 F. Supp. 626, 632 (D.N.H. 1982); *Pierucci v. Continental Casualty Co.*, 418 F. Supp. 704 (W.D. Pa. 1976); *New Hampshire-Vermont Health Service v. Whaland*, 119 N.H. 886, 893, 410 A.2d 642, 647 (1979) (per curiam); P. AREEDA, ANTITRUST LAW: AN

B. The Legislative History Compels the Conclusion that Section 47B Is a Statute that Regulates the Business of Insurance.

The legislative history of the McCarran-Ferguson Act provides further confirmation that Congress intended that federal laws like ERISA should not interfere with state statutes like Section 47B. Although the phrase "laws . . . which relate to the regulation . . . of [the] business [of insurance]" is not defined in the legislative history of the McCarran-Ferguson Act, that history indicates that Congress clearly understood that the Act would protect state laws regulating the terms and contents of insurance policies and the types of coverage and benefits offered. For example, Sen. Ferguson, one of the sponsors of the Act, observed that "a state law relating to . . . the fixing of the terms of a contract of insurance . . . would be permitted . . . ." 91 Cong. Rec. 480 (1945).[21] As this Court noted in *Prudential Ins. Co. v. Benjamin*, 328 U.S. 408, 430 (1946), "Congress must have had full knowledge of the nation-wide existence of state systems of regulation and taxation . . ." when it enacted the McCarran-Ferguson Act.

Moreover, that Act was intended to give the States very broad power to regulate the business of insurance. "The unequivocal language of the Act suggests *no* exceptions." *Western & Southern Life Ins. Co. v. State Board of Equalization*, 451 U.S. 648, 653 (1981) (emphasis added). Thus, Sen. Ferguson noted that the Act gave the States "full power to act by legislation . . . ." 91

ANALYSIS OF ANTITRUST PRINCIPLES AND THEIR APPLICATION 43 (1982 Supp.); Brummond, *supra* note 5, at 104; Manno, *supra* note 11, at 53.

[21] *See also, e.g.*, 90 CONG. REC. 6561 (1944) (remarks of Rep. Anderson) ("the States [do] have a right to control risks . . . and all the other things which the average insurance men recognize come under State regulations"); *id.* at 6528 (remarks of Rep. Miller); *id.* at 6536 (remarks of Rep. Howell); *id.* at 6538 (remarks of Rep. Springer); *id.* at 6546 (remarks of Rep. Voorhis); *id.* at 6556 (remarks of Rep. Graham).

Cong. Rec. 1481 (1945).[22] And throughout the legislative history, the observation was frequently made that the Act was meant to give the States broad discretion "to regulate insurance as they each see fit." S. Rep. No. 1112, 78th Cong., 2d Sess. 5 (1944).[23]

Moreover, the latitude given the States to regulate the business of insurance was not meant to apply only to the precise forms of state regulation in existence in 1945 when the McCarran-Ferguson Act was passed. Rather, the Act was intended to permit the States to take steps to resolve any unforeseeable problems that might face the insurance industry in the future. *See* 91 Cong. Rec. 483 (1945) (remarks of Sen. Radcliffe). Congress therefore recognized that the States would continue to make use of "experimentation" in regulating insurance, S. Rep. No. 1112, 78th Cong., 2d Sess. 6 (1944), to ensure "[p]rogress in insurance," which "can be made only by constantly liberalizing coverage and constantly reducing costs." 90 Cong. Rec. 6550 (1944) (remarks of Rep. Ploeser). Thus, "enactment of the McCarran-Ferguson Act 'put the full weight of [Congress'] power behind existing *and future* state legislation . . . .'" *Western & Southern Life Ins. Co. v. State Board of Equalization*, 451 U.S. at 654 (quoting *Prudential Ins. Co. v. Benjamin*, 328 U.S. at 431) (emphasis added).

The McCarran-Ferguson Act was also meant to protect state insurance laws from preemption by federal statutes that might later be enacted. Thus, Sen. Ferguson explained, "if Congress should tomorrow pass a law relating to interstate commerce, and should not specifically apply the law to the business of insurance, it would not be an implied repeal of this bill, and this bill would not be affected . . . ." 91 Cong. Rec. 481 (1945).[24] The McCarran-Ferguson Act therefore "remov[ed] obstructions [to state regulation of insurance] which might be thought to flow from [Congress'] power, whether dormant or exercised, except as otherwise expressly provided in the Act itself *or in future legislation.*" *Prudential Ins. Co. v. Benjamin*, 328 U.S. at 429-30 (emphasis added).[25]

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[22] *See also, e.g.*, 91 CONG. REC. 483 (1945) (remarks of Sen. Radcliffe); 90 CONG. REC. 6559 (1944) (remarks of Rep. Sumners); *St. Paul Fire & Marine Ins. Co. v. Barry*, 438 U.S. 531, 551 (1978) (referring to "the overall framework of plenary state regulation . . .").

[23] *See also* 91 CONG. REC. 1481 (1945) (remarks of Sen. Ferguson); 90 CONG. REC. 6418 (1944) (remarks of Rep. Allen).

[24] Although the McCarran-Ferguson Act provides that a federal law that "*specifically relates* to the business of insurance" may be construed to preempt state insurance regulations, 15 U.S.C. § 1012(b) (emphasis added), that provision is not applicable in this case. ERISA is not a law that specifically relates to the business of insurance. Rather, ERISA specifically relates to employee benefit plans. Moreover, it is difficult to understand how ERISA can be viewed as a statute explicitly designed to repeal the McCarran-Ferguson Act and to preempt state insurance regulations when ERISA expressly indicates *no* intent to displace state insurance laws and *no* intent to supersede the McCarran-Ferguson Act. *See Cochran v. Paco, Inc.*, 606 F.2d 460, 464 (5th Cir. 1979); *Wadsworth v. Whaland*, 562 F.2d 70, 78 (1st Cir. 1977), *cert. denied*, 435 U.S. 980 (1978).

Two courts have found that some portions of ERISA do specifically relate to the business of insurance within the meaning of the McCarran-Ferguson Act. *See Hewlett-Packard Co. v. Barnes*, 571 F.2d 502, 505 (9th Cir.) (per curiam), *cert. denied*, 439 U.S. 831 (1978); *Wayne Chemical, Inc. v. Columbus Agency Service Corp.*, 426 F. Supp. 316, 320 n. 1 (N.D. Ind. 1977), *modified on other grounds*, 567 F.2d 692 (7th Cir. 1977). But neither court articulated a persuasive rationale for its conclusion.

[25] The portion of the McCarran-Ferguson Act providing that the Act does not "affect in any manner the application to the business of insurance . . ." of the NLRA is not relevant to this case—even though some of the employee benefit plans that purchase insurance policies from appellants are the result of collective bargaining. 15 U.S.C. § 1014. That provision was meant to codify this Court's decision in *Polish Nat'l Alliance v. NLRB*, 322 U.S. 643 (1944), which held that the labor relations of insurance companies are subject to the NLRA. *See, e.g.*, 91 CONG. REC. 1090 (1945) (remarks of Rep. Gwynne); 90 CONG. REC. 6419 (1944) (remarks of Rep. Allen); Weller, *The McCarran-Ferguson Act's Antitrust Exemption for Insurance: Language, History and Policy*, 1978 DUKE L.J. 587, 594. Thus, that section provides only that the McCarran-Ferguson Act does not "jeopardize the rights of insurance workers . . ." under the NLRA; it therefore has no application

Thus, the McCarran-Ferguson Act was drafted to protect the long tradition of state regulation of the business of insurance. Because mandated benefit statutes like Section 47B regulate the business of insurance within the meaning of the McCarran-Ferguson Act, that statute requires, as a matter of federal policy, that such state statutes be preserved. Thus, this case involves more than a conflict between a state law—Section 47B—and a federal law—ERISA. Rather, it involves a conflict between two federal laws—ERISA and the McCarran-Ferguson Act. Resolution of such a conflict might be difficult if Congress had not indicated on two separate occasions in ERISA that the important policies underlying the McCarran-Ferguson Act should prevail. Given the two express exceptions to the reach of ERISA's preemption provision—the insurance savings clause and the provision indicating that ERISA is not intended to impair any federal law—any conflict between ERISA and the McCarran-Ferguson Act must be resolved in favor of the latter, and therefore in favor of mandated benefit statutes like Section 47B.

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to this case. 90 CONG. REC. 6526 (remarks of Rep. Brehm). *See also, e.g., Women in City Gov't United v. City of New York*, 515 F. Supp. 295, 304 (S.D.N.Y. 1981); *John Hancock Mutual Life Ins. Co. v. Commissioner of Ins.*, 349 Mass. 390, 397-98, 208 N.E.2d 516, 522 (1965).

Likewise, the NLRA does not itself preempt Section 47B. *See Malone v. White Motor Corp.*, 435 U.S. 497, 504-05 (1978) (noting that "nothing in the NLRA . . . expressly forecloses all state regulatory power with respect to those issues, such as pension plans, that may be the subject of collective bargaining," and that in another statute, the predecessor to ERISA, Congress had "recognized and preserved state authority to regulate pension plans . . ." without distinguishing those established by collective bargaining); *see also Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 526 n. 23 (1981) (noting that where Congress preserves the States' role, the NLRA does not preempt state regulation).

III. APPELLANTS' NARROW READING OF THE INSURANCE SAVINGS CLAUSE IS UNSUPPORTABLE.

Appellants propose that ERISA's insurance savings clause be construed to preserve only "the traditional areas of state insurance regulation . . ."—for example, "licensing and examination of insurers, . . . minimum capital and surplus requirements, . . . [and] general oversight of insurance companies." Brief for Appellant Metropolitan Life Insurance Co. at 34-35. There is absolutely no support for this exceedingly narrow reading of the savings clause.

A. The Statutory Language, Legislative History, and Judicial Construction of the Relevant Statutes Do Not Support Appellants' Reading of the Insurance Savings Clause.

Appellants' proposed construction of the savings clause distorts the plain meaning of that clause, which broadly preserves "any law of any State which regulates insurance . . . ." It cannot be read to preserve only those insurance laws that are to appellants' liking.

Moreover, appellants' interpretation of the insurance savings clause renders it completely superfluous. ERISA's preemption provision supersedes only those state laws that "relate to" employee benefit plans. But the types of insurance regulations appellants consider "traditional" are in no way related to employee benefit plans. Rather, they relate solely to insurance companies. If the insurance savings clause is interpreted to preserve only those types of insurance regulations, it has no meaning whatsoever because such regulations are not even arguably preempted by ERISA.

In addition, there is no support for appellants' limited definition of traditional areas of state insurance regulation. In fact, there is a very long tradition of state statutes, like Section 47B, that prescribe the contents of insurance policies and that mandate that certain benefits be included in those policies. *See SEC v. Variable Annuity Life Ins. Co. of America*, 359 U.S. 65, 79 (1959)

(acknowledging "[t]he traditional state insurance department regulation of contract terms . . ."). That tradition was solidly established when ERISA was enacted in 1974—and even when the McCarran-Ferguson Act was enacted in 1945. If Congress had meant to exclude such traditional forms of state insurance regulation from the savings clause, it certainly would have so stated and would not have applied that clause to "any law of any State which regulates insurance . . . ." [26]

B. The Relevant Policy Considerations Do Not Support Appellants' Reading of the Insurance Savings Clause.

Because appellants' construction of the insurance savings clause is not supported by the relevant statutory language, legislative history, or caselaw, they perforce rely on policy considerations supposedly favoring their reading of that clause. But "[t]hese policy considerations were for Congress to weigh, and [this Court is] not free to ignore the language and history of [ERISA and the McCarran-Ferguson Act] even were [the Court] to disagree with the legislative choice." *North Haven Board of Education v. Bell*, 456 U.S. 512, 536 n. 26 (1982). Moreover, "[r]eferral to the legislators is particularly appropriate in this case, as the policy aspects may not be as one-sided as those painted by [appellants]." *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 256 n. 26 (1979) (Brennan, J., dissenting).

[26] In a case similar to this one, this Court rejected the Federal Government's narrow reading of the term "health insurance" as it appeared in another federal statute. The Court relied on the absence of a definition of the term in the statute or legislative history, and on the lack of support for the limited definition in the statutory language or legislative history. Accordingly, the Court concluded that the Federal Government had "offer[ed] no persuasive reasons why the term 'health insurance' in [26 U.S.C.] § 22(b)(5) should be limited to the particular forms of insurance conventionally made available by commercial companies." *Haynes v. United States*, 353 U.S. 81, 84 (1975). Similar reasoning requires rejection of appellants' narrow definition of the term "insurance" in the insurance savings clause.

Leaving the task of balancing the relevant policies to Congress is additionally appropriate in this case because it involves a conflict between two federal statutes and because Congress has already rejected attempts to amend ERISA so as to preempt state mandated benefit laws. *See* note 9, *supra*. Because *amici* believe that this Court should not involve itself in weighing the conflicting policy considerations at issue in this case, we discuss them only briefly and limit the discussion to points not addressed in the *amicus* brief of the Committee for Comprehensive Insurance Coverage.

Appellants' construction of the insurance savings clause would create an immense regulatory vacuum in the field of insurance. It would result in the preemption of all state statutes prescribing the contents of insurance policies—at least insofar as those statutes applied to policies sold to employee benefit plans governed by ERISA. For example, the statutes cited at pages 8-10 above would all be subject to preemption.[27] There is no federal system for the regulation of insurance to replace this comprehensive and traditional scheme of state regulation. And ERISA does not attempt to control the substance of health and welfare benefits. In fact, the bulk of ERISA is directed at pension plans, not at welfare plans like those at issue in this case.[28] Ceasing all governmental regulation of welfare benefit plans, other than ERISA's disclosure and

[27] Appellants' attempt to dismantle the traditional state regulation of the contents of insurance policies, leaving no federal regulation in its place, is the latest in a long line of attempts by the insurance companies to avoid regulation. *See, e.g., Polish Nat'l Alliance v. NLRB*, 322 U.S. 643, 648-49 (1944); 90 CONG. REC. 6537-38 (1944) (remarks of Rep. Celler); Weller, *supra* note 25, at 590, 592, 614.

[28] The statute's title suggests that Congress was primarily concerned with pension benefit plans. Moreover, the scarcity of regulatory provisions applicable to welfare benefit plans and the congressional hearings indicate that reform of private pension plans was Congress' main objective. *See* Brummond, *supra* note 5, at 61-63, 114, 115; *ERISA Preemption* Comment, *supra* note 5, at 1536 n. 4, 1546 n. 70.

fiduciary requirements, is completely inconsistent with the legislative history of the McCarran-Ferguson Act, which indicates that Congress wished to avoid "the grave danger, unless something is done at once, that the insurance companies will be absolutely unregulated." 90 Cong. Rec. 6548 (1944) (remarks of Rep. Hobbs). It is likewise inconsistent with the legislative history of ERISA, which indicates that Congress wished to preserve the existing scheme of state insurance regulation, and that Congress was concerned with the inadequacy of governmental regulation of employee benefit plans, *see, e.g.*, 29 U.S.C. § 1001.[29]

Appellants' proposal would be exceedingly difficult to administer. In defining "the traditional areas of state insurance regulation," they suggest a distinction between "the wide range of state laws designed to protect the insurance purchaser from improper or imprudent conduct by the insurance company" and "state laws whose purpose and effect is to control plan content or the relationship between the plan itself and the plan's beneficiaries." Brief for Appellant Metropolitan Life Insurance Co. at 34. Not only is state control over the content of insurance policies a traditional area of state insurance regulation, but the very purpose of such control is to protect the purchaser of insurance. Accordingly, appellants' attempted distinction has no meaning. Even appellants concede that their construction of the insurance savings clause may lead to "difficult line-drawing problems." *Id.* at 35.

In addition to ignoring the substantial policies disserved by their reading of the insurance savings clause, appellants exaggerate the importance of the policies allegedly supporting their proposal. Appellants argue, for example, that mandated benefit statutes make it more difficult for interstate employers to provide uniform benefits

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[29] *See also Insurance Comm'r v. Metropolitan Life Ins. Co.*, 296 Md. 334, 343-44, 463 A.2d 793, 798 (1983); *Metropolitan Life Ins. Co. v. Whaland*, 119 N.H. 894, 903, 410 A.2d 635, 640 (1979) (per curiam).

and therefore create increased administrative costs for such employers. Although Congress may have wished to minimize the need for interstate employers to administer their plans differently in different states, it was also willing to sacrifice that interest to accommodate the States' interests. For example, ERISA permits continued enforcement of state laws relating to workmen's compensation, unemployment compensation, and disability insurance, although they vary substantially from state to state. *See* 29 U.S.C. § 1003(b)(3). Moreover, the insurance savings clause permits the States to enforce at least some insurance laws relating to employee benefit plans, even though those laws likewise differ among the States. Thus, "[m]ere incantation of the congressional goal of uniformity in regulation cannot resolve this question of statutory construction." *Standard Oil Co. v. Agsalud*, 442 F. Supp. 695, 706 (N.D. Cal. 1977), *aff'd*, 633 F.2d 760 (9th Cir. 1980), *aff'd mem.*, 454 U.S. 801 (1981).

Moreover, because state laws have traditionally prescribed the contents of insurance policies, diversity in this area has long been the norm for interstate employee benefit plans. And it was precisely such diversity that the McCarran-Ferguson Act was intended to preserve.[30] There is no evidence in ERISA's legislative history that Congress intended to sacrifice this diversity; in fact, Congress' concern for uniformity appears to have been limited to regulation of benefit plans, and not to regulation of insurance companies selling policies to those plans. *See, e.g.*, 120 Cong. Rec. 29,933 (1974) (remarks of Sen. Williams).

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[30] *See, e.g., Prudential Ins. Co. v. Benjamin*, 328 U.S. 408, 431 (1946) ("Congress intended to declare, and in effect declared, that uniformity of regulation, and of state taxation, are not required in reference to the business of insurance by the national public interest, except in the specific respects otherwise expressly provided for"); 90 CONG. REC. 6418-19 (1944) (remarks of Rep. Allen); *id.* at 6550 (remarks of Rep. Robsion); *id* at 6551 (remarks of Rep. Ploeser).

Appellants also argue that mandated benefit statutes encourage employee benefit plans to become self-insured. However, there is no evidence in ERISA's language or legislative history that self-insurance is contrary to Congress' intent. In fact, Congress clearly recognized that some employee welfare benefit plans would not purchase insurance policies. *See* 29 U.S.C. § 1002(1). Moreover, the States have every incentive to discourage self-insurance to maximize the impact of mandated benefit statutes and other state insurance regulations, as well as to prevent "a loss of revenue from the traditional state source of insurance company taxation, the premium tax . . . ." Okin, *supra* note 5, at 671.

Thus, although judicial balancing of the countervailing policy considerations is especially inappropriate in this case and should instead be left for Congress, the relevant policies support the decision below.

CONCLUSION

Amici urge this Court to affirm the decision below.

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BRIEF

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No. 84-325, 84-356.

In the
Supreme Court of the United States.

OCTOBER TERM, 1984.

METROPOLITAN LIFE INSURANCE COMPANY,
APPELLANT,
v.
COMMONWEALTH OF MASSACHUSETTS,
APPELLEE.

THE TRAVELERS INSURANCE COMPANY,
APPELLANT,
v.
COMMONWEALTH OF MASSACHUSETTS,
APPELLEE.

ON APPEALS FROM THE SUPREME JUDICIAL COURT FOR THE COMMONWEALTH OF MASSACHUSETTS.

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Questions Presented.

I. Whether a Massachusetts statute requiring that all health insurance policies issued in the state include minimum mental health benefits is protected from preemption by the Employee Retirement Income Security Act of 1974 (ERISA), because of an express ERISA exemption for state insurance laws (29 U.S.C. § 1144 (b)(2)(A)).

II. Whether a Massachusetts statute requiring that all health insurance policies issued in the state include minimum mental health coverage is preempted by the National Labor Relations Act (NLRA), 29 U.S.C. §§ 151 *et seq*.

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No. 84-325, 84-356.

In the Supreme Court of the United States.

OCTOBER TERM, 1984.

METROPOLITAN LIFE INSURANCE COMPANY,
APPELLANT,

v.

COMMONWEALTH OF MASSACHUSETTS,
APPELLEE.

THE TRAVELERS INSURANCE COMPANY,
APPELLANT,

v.

COMMONWEALTH OF MASSACHUSETTS,
APPELLEE.

ON APPEALS FROM THE SUPREME JUDICIAL COURT FOR THE COMMONWEALTH OF MASSACHUSETTS.

Brief for the Appellee.

Statement of the Case.

The Commonwealth is "dissatisfied", within the meaning of Supreme Court Rule 34.2, with the appellants' Statements of the Case[1] because the appellants continue to press factual and policy arguments which are inconsistent with the findings of the Massachusetts legislature and the trial court. Accordingly, the Commonwealth submits the following to supplement the appellants' statements.

1. This case involves preemption-based challenges to a Massachusetts insurance law that prescribes certain terms to be contained in insurance policies issued in the Commonwealth which provide coverage for hospital and surgical expenses. The statute under attack is codified at Mass. G. L. c. 175, § 47B (West Supp. 1984-1985) (hereinafter, § 47B).[2]

There can be no question that the Massachusetts state legislature adopted § 47B to address the problem of treating mental illness in the Commonwealth and not to avoid the strictures of ERISA. (General Court Joint Committee on Insurance, "Advances in Health Insurance in Massachusetts," 1974, A. 426-458).[3]

In passing the measure in December, 1973, the legislature felt compelled to act because federal policy in the area at that time did not adequately address Massachusetts' or other states'

[1] Brief of Appellant Metropolitan Life Ins. Co. (Metropolitan) at 3-9; Brief of Appellant Travelers Ins. Co. (Travelers) at 2-9.

[2] Section 47B is set forth in its entirety at J.S. App. 87a-89a. J.S. App. refers to the separately bound appendix to the Jurisdictional Statements filed by appellants.

[3] "A." refers to the separately bound Joint Appendix filed by the parties pursuant to Rule 30.

problems (A. 427). Specifically, the legislature perceived that mental health treatment in Massachusetts was inadequate in two basic respects: (1) the large majority of persons who evidenced a need for mental health treatment, namely members of the poor and working segments of society, were not receiving it because they could not afford it, and (2) those persons within the groups who were receiving treatment were generally institutionalized in state-run facilities and were not receiving treatment from community mental health centers, where, it was generally thought, persons could be treated on an out-patient basis and could continue to function within the mainstream of society (A. 430-432).[4]

The legislature recognized that both these treatment inadequacies were at least partially the result of the state of the market for mental health insurance. Because they could not afford it, persons who needed help were unable to obtain mental health insurance which would help pay for their treatment. That payment would in turn support payment of expenses at community-based mental health centers, which would encourage their proliferation across the state and diminish the need for and utilization of state institutions (A. 432-433).

The legislature's recognition that the problems with the treatment of mental illness in Massachusetts stemmed from problems associated with selling mental health insurance in the Commonwealth is precisely on point. Testimony presented by the Commonwealth at trial (A. 219-233), which the trial court

[4] The legislature also understood (and testimony was presented which indicated) that because mental illness was not being treated, or was being treated on an institutionalized basis, Massachusetts was also suffering indirect costs to its economy. Indirect costs include the losses of income and the decreased productivity of workers which result from disability or death due to mental illness and include the incorrect over-utilization of non-psychiatric medical care for mental problems (J.S. App. 51a; A. 209-212, 218-219).

adopted as part of its findings, (J.S. App. 50a), indicated that the market for mental health insurance had become retracted. This retraction of the market was found to be the result of the phenomenon of adverse selection; insurance companies found they could not compete by offering an adequate package of mental health insurance coverage (A. 223-225).

The principle of adverse selection deserves full explanation. It simply means that in a voluntary market poor insurance risks choose to buy mental health insurance. "Good risks" for mental health insurance, *i.e.*, people who do not anticipate using the mental health benefit, do not buy the insurance because premiums are established based on an average price for both good and bad risks, and are therefore too expensive to attract good risks (A. 222). "Bad risks", *i.e.*, people who predict that they will utilize the benefit, buy the insurance, because for them, the average price is attractively low (A. 222). Thus, in a *voluntary* market, insurance companies which sell mental health benefits draw an "*adverse selection*" of the population, *i.e.*, a group dominated by bad risks who will utilize the benefit (A. 223-224).

Ironically, if an insurer reacts to the adverse selection phenomenon by raising premiums, the insurers actually attract a worse collection of bad risks (A. 224). This is so because the good risks who buy the benefit at the "average price," refuse to buy the benefit at the "adverse selection" price. In addition, competition among insurance companies for "good risks" exacerbates the effects of adverse selection; companies which reduce the extent of coverage offered and therefore are able to lower their premiums cause good risks to abandon the insurer with the "adverse selection" of risks. Thus, a competitive and voluntary market creates continual retraction of the mental health insurance market. This cycle destroys the marketability of mental health benefits (A. 224-225).

Massachusetts' solution to the mental health treatment problem was to enact a statute, § 47B, which regulates the types of insurance policies sold in the Commonwealth. All policies

providing coverage for hospital and surgical expense are now required to provide minimum benefits for inpatient and outpatient mental health treatment.[5]

Mandating of minimum levels of mental health insurance as prescribed by § 47B in a market controlled by adverse selection served to correct the retracted state of the insurance market (A. 225-227). Because minimum coverage levels were required, companies did not have to engage in the "ruinous competition for the good risks, leaving the bad risks with their competitors." (A. 225.) Under a mandated benefits policy, "[t]he government mandate can mimic the result of a market if it were able to work correctly by setting prices appropriate for individuals." (A. 226.) The good risks and the bad risks are spread around so that the insurance companies can survive while continuing to provide the benefits (A. 225-226). Mental health insurance is available for everyone to purchase at a price which they can afford (A. 225-226).[6]

This discussion of the purpose of § 47B is not a *post hoc* rationalization offered by the state's attorney. Instead these arguments emerge from an unusal legislative report detailing a number of the public policy goals of the statute. These include (1) the need to provide the public with affordable comprehensive inpatient and outpatient mental health care, (2) the foster-

[5] Section 47B also requires employee benefit plans to provide the same minimum health benefits. With the enactment of ERISA in 1974, however, the Attorney General acknowledged that application of its terms to such plans was preempted. Therefore, the Commonwealth has not sought to enforce § 47B directly against uninsured employee benefit plans. *See* discussion of the pre-ERISA state regulation of employee benefit plans at 27-29, *infra*.

[6] It is important to note that the 1973 statute contained parallel provisions providing for the inclusion of protection against mental illness costs, not just in health insurance policies and employee health and welfare plans, but also in hospital and medical services contracts. Mass. St. c. 1174, §§ 3-6, codified at Mass. G. L. c. 176A, § 8A (West Supp. 1984-1985) and c. 176B, § 4a (West Supp. 1984-1985). Three years later, when health maintenance organizations had emerged as significant providers of medical services, the requirements of § 47B were made applicable to them. Mass. G. L. c. 176G, § 4 (West Supp. 1984-1985).

ing of community-based mental health care as an alternative to state-subsidized institutionalization, (3) the reduction of medical care expenditures for mentally-related illness and (4) the provision of relief to the Commonwealth from some of the financial burden of resolving mental health problems (J.S. App. 52a-53a).

2. The statutes said to preempt § 47B are ERISA and the NLRA (J.S. App. 85a-87a, 89a-91a). ERISA contains a series of express preemption clauses: § 514(a), 29 U.S.C. § 1144(a) generally preempts state laws which relate to employee benefit plans; § 514(b), 29 U.S.C. § 1144(b) saves from preemption state laws which regulate insurance. The NLRA contains no express preemption scheme; therefore, the question of state law preemption by the NLRA turns on the implied intent of Congress.

3. This case originated on June 1, 1979, when the Attorney General filed a civil complaint in the Superior Court of Massachusetts (A. 6-49). In that complaint, the Attorney General requested both a declaration that, the provisions of ERISA and the NLRA notwithstanding, the Metropolitan and Travelers insurance companies were required to issue policies containing the benefits required by § 47B, and injunctive relief effectuating the declaration (A. 11-12). The defendant insurance companies had not themselves challenged the statute, and no ERISA plan was a party to the suit (A. 6-12). A preliminary injunction issued on August 28, 1979 (A. 57-59). The case was heard on its merits between September 22 and 29, 1980. The Findings and Conclusions of the trial court are set forth at J.S. App. 36a-62a.

Throughout this litigation, the Commonwealth has asserted that § 47B is exempt from preemption because ERISA's plain language saves "any law . . . of any state which regulates insurance. . . " 29 U.S.C. § 1144(b)(2)(A) and because Congress did not intend for statutes regulating the types of insurance policies which may be issued in Massachusetts to be preempted by the NLRA (J.S. App. 86a, 89a-91a). The courts of the Commonwealth have consistently reached the same conclusion regarding ERISA, albeit by a somewhat narrower reading of the insurance savings clause than that proposed here. As to both the NLRA and ERISA, the courts also based their decisions on an examination of the practical interplay of § 47B with ERISA and the NLRA (J.S. App. 4a-7a, 17a-34a, 36a-62a).

The trial court rejected the insurers' arguments that § 47B conflicted and interfered with the purposes of ERISA (J.S. App. 51a-56a). The insurers argued that variations from state to state in insurance laws such as § 47B would effect a lack of uniformity in multistate employee benefit plans and also argued that § 47B imposes cost burdens and encourages bankruptcy or promotes self-insurance of employee benefit plans. In rejecting these arguments, which the insurers continue to stress even now, the trial court found as a matter of fact that

> (1) the administrative burden imposed by mandated benefit laws, including diverse eligibility requirements for each state, is no more complex or burdensome to interstate commerce than various other multistate regulatory schemes such as workmen's compensation laws;
>
> (2) the insurers presented no credible evidence that even assuming every state had enacted mandated benefit laws with varied eligibility requirements, such diversity and nonuniformity would be any more complex or burdensome to interstate commerce than other diverse multistate regulatory schemes, such as workmen's compensation laws;
>
> (3) the insurers introduced no credible evidence establishing that the trend toward self-insurance is more pronounced in Massachusetts by virtue of the enactment of § 47B;
>
> (4) the insurers presented no credible evidence of the actual cost insurers would incur if they complied with § 47B;
>
> (5) the insurance companies produced no credible evidence that they could not absorb the cost of compliance

with § 47B; or that any ERISA plan in the United States had gone bankrupt because of compliance with a mandated benefit statute; and

(6) the insurers produced no credible evidence that the cost-impact of § 47B has forced any policy holder to self-insure or that the trend toward self-insurance is more pronounced in Massachusetts because of § 47B.

(J.S. App. 54a-56a).

The trial court also rejected the insurers' preemption arguments under the NLRA. It found that statutes mandating benefits are no more disruptive to the collective bargaining process than statutes requiring coverage for pregnancy-related disabilities, and that collective bargaining agreements frequently differ from state to state due to differences in state law (J.S. App. 55a).

4. Following entry of an amended final judgment on December 1, 1980, this case has twice been before the Supreme Judicial Court of the Commonwealth (SJC), which has twice rejected the insurance companies' arguments.

In its first opinion, the highest court of the state noted that ERISA's savings clause for state insurance laws was broad enough to permit a reading saving § 47B from preemption. *Atty. Gen.* v. *Travelers Ins. Co.*, 385 Mass. 598 (1982), *vacated and rem'd* ____ U.S. ____, 103 S.Ct. 3563 (1983) (J.S. App. 21a). The SJC held that § 47B was not preempted because of the language of ERISA's preemption and savings clauses and the absence of any conflict between ERISA and § 47B (J.S. App. 22a-25a). On the matter of the NLRA, the court concluded that the statute, as a health regulation implemented through the mechanism of insurance, was saved from preemption by Congress' intent that the NLRA not supersede either local health regulation or state insurance laws within the meaning of the McCarran-Ferguson Act, 15 U.S.C. §§ 1011 *et seq.* (J.S. App. 25a-30a). The court also viewed § 47B as not having an absolute limit restricting unions' and employers' abilities to negotiate the terms of collective bargaining agreements (J.S. App. 31a).

On appeal, this Court vacated the SJC's decision and remanded the case for reconsideration in light of *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 103 S.Ct. 2890 (1983) (J.S. App. 10a).

On remand, the SJC focused on the ERISA issues to the exclusion of the insurers' renewed NLRA arguments, and again found that ERISA did not preempt § 47B. *Attorney General* v. *Travelers Ins. Co.*, 391 Mass. 730 (1984) (J.S. App. 1a-9a). Considering the issues now in light of *Shaw*, the SJC found significance in the fact that *Shaw* does not address the insurance savings clause in ERISA (J.S. App. 4a). Using *Shaw's* analysis that effect must be given to ERISA's plain language, 103 S. Ct. at 2900, the court reiterated its previous view that in light of the absence of any conflict between ERISA's purposes and the operation of § 47B, and the plain words exempting from preemption "any law of any state which regulates insurance," § 47B should survive (J.S. App. 6a).

The SJC concluded that to read ERISA as preempting § 47B would "read into the statute an intent that is not expressed by plain words or by necessary implication" and would "require an unnaturally narrow reading of the phrase 'any law . . . which regulates insurance. . . ." (J.S. App. 6a). The court held that § 47B was a "bona fide regulation of insurance" and was "within the spirit, as well as the letter, of the insurance exception to ERISA preemption" and therefore should not be preempted (J.S. App. 7a). It is this conclusion which the insurance companies ask this Court to reverse.

Summary of Argument.

1. Neither the plain language of ERISA, its legislative history, nor its clear purpose support the premise that state statutes regulating the content of insurance policies that may be sold in the state are preempted when applied to insurance policies purchased to provide benefits in employee welfare plans.

By means of ERISA, Congress sought to combat fraud and abuse in pension plan management by requiring extensive disclosure and the application of fiduciary standards to the management of pension funds. To a far lesser extent, but for the same purposes, Congress sought to regulate welfare plans.

When Congress enacted ERISA and broadly preempted state laws relating to pensions and employee welfare plans, Congress specifically saved from preemption state insurance laws. Throughout the development of ERISA, Congress always contemplated the continued regulation of insurance by the states. Congress recognized in ERISA, as it earlier had in the McCarran-Ferguson Act, 15 U.S.C. §§ 1011 *et seq.*, that state insurance laws constituted a well-developed body of laws which the states had created and enforced and which should not be interfered with by federal legislation. Accordingly, by explicitly exempting state insurance laws from preemption, Congress made a conscious policy decision to allow the states to continue to regulate insurance, including insurance purchased to provide benefits in employee welfare plans.

Section 47B is a state insurance law within the meaning of ERISA's savings clause. Section 47B, which was enacted prior to the enactment of ERISA, lies squarely within the traditional realm of state regulation of insurance enunciated by this Court in *SEC* v. *National Secur., Inc.*, 393 U.S. 453 (1969) because it regulates the terms of the contract between the insured and the insurer, alters the voluntary insurance market and spreads the risk and cost of mental illness among Massachusetts' citizens, thereby ensuring that the benefits of treatment are available at a reasonable cost to all citizens in need.

Finally, the insurers' policy arguments regarding the effect of mandated benefit laws, such as § 47B, on employee benefit plans and insurance are misdirected, overstated and find no support in the record or in the literature of insurance regulation, economics or mental health.

2. Because § 47B is a law which simply requires that all health insurance policies issued in the state provide minimum coverage for health benefits, it does not impact on the collective bargaining process nor interfere in any way with federal labor law policy; hence, given the presumed validity of state laws, it should not be preempted by the NLRA.

The declared policy of Congress in enacting the NLRA was the promotion of the collective bargaining process and the encouragement of labor and management to negotiate their differences in good faith to achieve industrial peace and eliminate obstructions to the free flow of interstate commerce. Preemption of state laws requires a clear conflict with or frustration of this policy. Those state laws which have been preempted by the NLRA have suffered invalidation because they frustrated the federal scheme in some way, either by interfering with the National Labor Relations Board's (NLRB's) ability to referee the collective bargaining process, or by "stacking the deck" in favor of one party over the other by denying a party an economic weapon in the collective bargaining process which Congress meant it to have. As a law which prescribes the types of insurance policies sold in Massachusetts, § 47B falls into neither of these categories of impermissible interference.

The appellants argue that § 47B does not merely regulate the types of health insurance which may be sold in Massachusetts; they maintain that § 47B dictates specific terms which must be contained in collective bargaining agreements, and consequently, that the exercise by the state in compelling the agreements to contain certain terms is a frustration of congressional intent in fashioning federal labor policy. The Commonwealth demonstrates, however, that the argument is fallacious. Nowhere in the federal scheme of labor-management relations is there an indication of congressional intent to permit the practice that the appellants hope to achieve, namely that unions and employers, acting together, may agree to terms in a collective bargaining agreement which employers would otherwise

be prohibited by state law from establishing. Collective bargaining was not intended by Congress to be a refuge for employers and unions from the operation of state laws which they perceive to be burdensome.

Congress has long recognized that states have the right to legislate and protect their citizens' health and their workers' employment conditions. Similarly, Congress has historically deferred to state regulation in the field of insurance. Congressional recognition of state authority in these areas is indicative of its intent to permit the states to continue to so regulate, in spite of any remote effect on labor-management relations.

Argument.

I. As a State Law Regulating the Content of Insurance Policies, § 47B is Not Preempted by ERISA.

A. *Preemption is Not Lightly Inferred, Particularly in an Area of Law Such as Insurance Regulation which has Historically Been a Concern of the States.*

In determining whether § 47B is preempted, "our task is to ascertain Congress' intent in enacting the federal statute at issue." *Shaw* v. *Delta Air Lines, Inc.*, 103 S. Ct. at 2890. A thoughtful examination of ERISA and its legislative history leads inexorably to the conclusion that Congress intended state insurance laws like § 47B to survive preemption. This is so first because "[t]he exercise of federal supremacy is not lightly to be presumed." *New York State Dept. of Social Services* v. *Dublino*, 413 U.S. 405, 413 (1973), quoting *Schwartz* v. *Texas*, 344 U.S. 199, 202-203 (1952).

This black letter proposition is no different with respect to ERISA. Indeed, in *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981), the first case construing the preemption lan-

guage of ERISA, this Court reiterated this basic principle governing preemption in the following terms:

> [p]reemption of state law by federal statute or regulation is not favored 'in the absence of persuasive reasons either that the nature of the regulated subject matter permits no other conclusion, or that Congress has unmistakably so ordained.' *Chicago & North Western Transp. Co.* v. *Kalo Brick & Tile Co.*, 450 U.S. 311, 317 (1981), quoting *Florida Lime & Avocado Growers, Inc.* v. *Paul*, 373 U.S. 132, 142 (1963). *See, Jones* v. *Rath Packing Co.*, 430 U.S. 519, 526-526 (1977); *Perez* v. *Campbell*, 402 U.S. 637, 649 (1971); *Rice* v. *Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947); *Hines* v. *Davidowitz*, 312 U.S. 52, 61-62 (1941).

Alessi v. *Raybestos-Manhattan Inc.*, 451 U.S. at 522.

This is especially true where, as here, the law sought to be preempted lies in an area such as insurance that Congress has historically left to the states to regulate.

> We start with the assumption that the historic police powers of the states were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress.

Jones v. *Rath Packing Co.*, 430 U.S. 519, 525 (1977), quoting *Rice* v. *Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947). Insurance law is perhaps the paradigm of such an area, since in the McCarran-Ferguson Act Congress has used its plenary authority to effectively approve what would otherwise amount to discriminatory commercial regulation by the states. *Western & Southern Life Ins. Co.* v. *State Bd. of Equalization*, 451 U.S. 648, 652-653 (1981); *Prudential Ins. Co.* v. *Benjamin*, 328 U.S. 408 (1946). The Commonwealth submits, therefore, that only the clearest manifestation of a congressional intent

to supersede state insurance laws would support appellants' claim of preemption. No such intent can be inferred in this case.

B. *ERISA was Not Intended to Displace State Laws Governing Insurance and Instead Explicitly Provides for Continued Enforcement of Such Laws.*

1. The Plain Language of the Statute.

The search for manifestations of congressional purpose is unusually easy in this case because the text of the statute itself makes it clear that no intent to preempt state insurance laws exists. As this Court has recently observed in the context of statutory construction, the exercise "must begin with the language employed by Congress and the assumption that the ordinary meaning of that language accurately expresses the legislative purpose." *Park 'n Fly, Inc.* v. *Dollar Park and Fly, Inc.*, ___ U.S. ___, ___, 53 U.S.L.W. 4044, 4046 (Jan. 8, 1985); *Mills Music, Inc.* v. *Snyder*, ___ U.S. ___, ___, 53 U.S.L.W. 4035, 4038 (Jan., 1985). It is to the text of the statute, therefore, that we first turn.

ERISA contains a series of preemption clauses, each of which must be read together to give the entire statute meaning. *E.g., Philbrook* v. *Glodgett*, 421 U.S. 707, 708-719 (1975). Section 514(a), 29 U.S.C. § 1144(a), ERISA's general preemption clause, provides that,

> Except as provided in subsection(b) of this section, the provisions of this subchapter and subchapter III shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title.

This general rule of preemption is followed by a "savings clause," § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A), on which the Commonwealth primarily relies in asserting that its statute may operate in the face of ERISA. That clause provides in pertinent part that ERISA shall not relieve any person from compliance with state insurance laws:

> Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

These two clauses are followed by the "deemer clause" which provides:

> Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies, [or] insurance contracts. . . .

29 U.S.C. § 1144(b)(2)(B).[7] Finally, this last clause is further modified by a congressional directive that ERISA is not construed to invalidate other federal legislation:

> Nothing in this subchapter shall be construed to alter, amend, modify invalidate, impair or supersede any law of the United States . . . .

29 U.S.C. § 1144(d).

Conceptually, then, ERISA's general preemption clause is limited by the insurance savings clause. It, in turn, is explicated

[7] The language of the deemer clause constitutes explicit recognition that Congress was aware that insurance regulation included regulation of the "contracts" issued by insurers, as well as the insurers themselves.

by the deemer clause, which serves to limit and define the breadth of the insurance savings clause. By forbidding the states from deeming or considering employee benefit plans to be insurers, Congress expressly stopped the practice of several of the states of regulating employee benefit plans by treating them as insurers.[8]

Congress' express prohibition against considering employee benefit plans to be insurance companies or insurance contracts reveals the breadth of the insurance savings clause because the deemer clause functions as the only explicit limitation in ERISA on the insurance savings clause. It would not be necessary to even insert such a deemer clause, unless the insurance savings clause is extremely broad — so broad that it would otherwise permit the savings clause to swallow up the rule of general preemption and allow the states to directly regulate employee benefit plans through state insurance laws. What these successive provisions mean, therefore, is simply that ERISA permits continued state regulation of insurance, but rejects state regulation of employee benefit plans.[9]

That Congress should choose this path accords with the central premise of the McCarran-Ferguson Act (McCarran Act) that the states are the primary regulators of insurance. 15 U.S.C. §§ 1011 *et seq*. By virtue of Congress' later inclusion in ERISA of the insurance savings clause and its express acknowledgment that ERISA does not alter or supersede existing federal law, 29 U.S.C. § 1144(d), Congress affirmed this basic McCarran-Ferguson principle.

This reading of ERISA's preemption clauses is further buttressed by Congress' express acknowledgment and acceptance of the role of insurance in the ERISA scheme. ERISA, for example, provides that employee benefit plans may provide bene-

[8] *See* historical discussion of state regulation of employee welfare plans at 27-29, *infra*.

[9] Pfennigstorf & Kimball, *Employee Legal Service Plans: Conflicts Between Federal and State Regulation*, 1976 A. B. Found. Research J. 787, 818 (hereinafter Pfennigstorf).

fits "through the purchase of insurance or otherwise." 29 U.S.C. § 1002(1). Read with the "savings" and "deemer clauses," one must conclude that Congress intended continued state regulation of insurance and its concomitant protection of the insureds.[10]

2. The Prior Opinions of this Court Addressing ERISA Preemption Support the Reading of ERISA Advanced by Massachusetts.

In spite of the literal language of ERISA, the insurers assert that ERISA's preemption scheme somehow alters the traditional preemption test. They assert that this Court's two decisions addressing ERISA preemption, *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981), and *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 103 S. Ct. 2890 (1983), confirm their view that through ERISA Congress sought to foreclose any non-federal regulation that affects employee benefit plans. But the insurers substantially mischaracterize the holdings and discussions in *Alessi* and *Shaw*. Both cases explicitly confirm that preemption is not favored unless the state law in question is specifically and clearly excluded by ERISA. *Alessi* at 522; *Shaw* at 2905.

Because this case involves state regulation of insurance, *Alessi* does not avail the petitioners. In *Alessi*, this Court struck down a state law which prohibited a practice, "set-off," which ERISA explicitly permits. 451 U.S. at 517-525. Given the clear conflict between the two statutes and the breadth of ERISA's preemption clause, the Court concluded that the operation of ERISA evidenced an unmistakable intent of Congress that the New Jersey statute fall to the Supremacy Clause. Nevertheless, the Court rejected the notion, now advanced by the insurers, that ERISA expresses a congressional desire to

[10] When employee benefit plans supply benefits through the purchase of insurance, the covered employees acquire significant rights under state law against the insurer. *See Wayne Chemical, Inc.* v. *Columbus Agency Service Corp.*, 567 F.2d 692 (7th Cir. 1977).

foreclose any state regulation which relates in any way to employee benefit plans, noting that "[t]he scope of federal concerns, however, is limited by ERISA itself. The statute explicitly preserves state regulation of insurance, banking and securities." 451 U.S. at 523 n.19.

In *Shaw*, this Court considered whether the New York Human Rights Law and Disability Benefits Law fell within any of the specific exceptions in ERISA to the general rules of preemption contained in § 514a, 29 U.S.C. § 1144(a). In construing those statutory provisions this Court followed the plain meaning of the pertinent exemptions from preemption. 103 S.Ct. at 2903, 2905.[11]

In considering the Human Rights Law, the Court first found that it was a law which relates to an employee benefit plan and then proceeded to weigh the effect of an exemption that is not a subject of the case at bar, the exemption contained in § 514(d) providing that § 514(a) shall "not be construed to alter, amend, modify, invalidate, impair or supersede any law of the United States." Section 514(d), 29 U.S.C. § 1144(d). The Court's analysis carefully tracked the language of the exemption and relied heavily on the congressional intent expressed in Title VII of the Civil Rights Act of 1964, 78 Stat. 253, as amended, 42 U.S.C. §§ 2000e *et seq*. Noting the significant role of state laws in the enforcement of Title VII, the Court concluded that complete preemption of the Human Rights Law would disrupt the joint federal-state enforcement scheme contemplated by Title VII and would therefore "modify and impair federal law" within the meaning of § 514(d). 103 S.Ct. at 2903. Thus, the Court found no preemption to the

[11] The Human Rights Law, a comprehensive anti-discrimination statute, was challenged insofar as it mandated employee benefit plans to treat pregnancy the same as other occupational disabilities. The Disability Benefits Law required employers to pay certain benefits to employees unable to work because of non-occupational injuries or illnesses and as amended, mandated the same benefits for pregnancy as for any other disability. The employers in *Shaw* provided their employees with various medical and disability benefits through welfare plans subject to ERISA, but did not provide pregnancy benefits.

extent that the Human Rights Law extended the same substantive protections as Title VII, but found that the Supremacy Clause prohibited its application insofar as the Human Rights Law created substantive rights additional to those provided by Title VII.

In making this ruling, the Court strongly intimated that the reading of the savings clause advanced here by the Commonwealth is correct. The Court compared and contrasted the extremely broad scope of § 514(b), the savings clause relied on by the state, with the narrow exemption worked by § 514(d). In analyzing the Human Rights Law *vis a vis* § 514(d), the Court looked at its precise relationship to Title VII and upheld it only in part. The Court contrasted this piecemeal approach to the general § 514(b) exemption for state banking, insurance and securities laws. *Id*. at 2903-2904.

It is also significant to the arguments advanced by the insurers that the Court acknowledged that while a state may not force an employer to comply with the state disability law as part of its multi-benefit plan, a state may force an employer to maintain a separate disability benefit plan and thereby comply with the Disability Benefits Law:

> In other words, while the state may not require an employer to alter its ERISA plan, it may force the employer to choose between providing disability benefits in a separately administered plan and include the state-mandated benefits in its ERISA plan. If the state is not satisfied that the ERISA plan comports with the requirements of its disability insurance law, it may compel the employer to maintain a separate plan that does comply.

103 S.Ct. at 2905-2906. In other words, the Court noted its approval of a statutory scheme that would indirectly dictate the contents of an ERISA plan and thereby detract from uniformity of multi-state benefit plans.

Thus, despite the insurers' protestations, both *Alessi* and *Shaw* confirm the historic presumption against preemption of state law and counsel adherence to the plain language of ERISA's exceptions to preemption. Equally important, neither *Alessi* nor *Shaw* turned on the application of the savings clause for insurance, the key to this controversy, and each intimated that the section could protect a state law such as § 47B from preemption.

The Commonwealth reads the ERISA preemption scheme as plainly saving § 47B. Such a reading accords with the holding in *Wadsworth* v. *Whaland*, 562 F.2d 70 (1st Cir. 1977), *cert. denied*, 435 U.S. 980 (1978). The *Wadsworth* court recognized that the savings clause reading urged by the insurers renders the savings clause meaningless. *Wadsworth* at 78. In the absence of the savings clause the only state insurance laws that would be preempted by ERISA's general preemption clause would be those that indirectly regulate employee welfare plans. Other insurance laws would not be preempted because they neither relate to nor affect employee benefit plans. As the Solicitor General wrote in his memorandum opposing the grant of *certiorari* in the *Wadsworth* case:

> The court of appeals recognized, however, that Chapter 57 indirectly regulated employee benefit plans (and all other insureds) by limiting the choices available to them if they choose to buy insurance. Because Section 514(b)(2) subjects to preemption even those state laws which indirectly regulate plans, the court of appeals found Chapter 57 would be subject to preemption. At this point, however, Section 514(b)(2)(A) comes into play; that sub-section saves from preemption any state law which 'regulates insurance'. This savings provision would be meaningless unless it saved from preemption state laws regulating insurance which also indirectly regulate employee benefit plans, since no other state law regulating insurance would be subject to preemption under the Act even in the absence of the savings provision. Chapter 57 obviously 'regulates insurance', and thus the court correctly found that Congress intended that law and others like it to remain effective regardless of ERISA's otherwise broad preemption of state laws relating to plans.

Memorandum for the United States As Amicus Curiae, On Petitions For Writs of Certiorari at 6-7, *Wadsworth* v. *Whaland*, 562 F.2d 70 (1st Cir., 1977), *cert. denied*, 435 U.S. 980 (1978). The Commonwealth wholeheartedly agrees with this proposition.

3. The Legislative History Regarding ERISA Preemption.

The appellants reject the Commonwealth's straight-forward reading of the statutory text as being overly simplistic. Their alternative reading of the statute, clumsy as it might be, can only withstand scrutiny if clearly supported by the legislative history, for it finds no support in the statutory language itself. That legislative history, while offering scant information regarding the insurance savings clause, supports the Commonwealth's literal reading of the savings clause. First, even the earliest versions of ERISA contained exceptions from preemption for traditional areas of state concern such as insurance and banking. Second, the changes which were made in the statute as it made its way through Congress do not suggest any narrowing of the scope of the insurance savings clause.

Pre-enactment versions of ERISA in both the House of Representatives and the Senate contained almost identical preemption clauses which were a great deal narrower than the general preemption clause now in ERISA.[12]

Appellants argue that the broadening of the preemption clause by the Conference Committee means that Congress meant to foreclose *any* non-federal regulation of employee benefit plans. (*See* Metropolitan Brief at 14 and 15). But this reading renders the savings clause for insurance meaningless.

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[12] *See* § 514(a) of H.R. 2, 93d Cong. 1st Sess. (1973), 120 Cong. Rec. 4742 (1974), and 120 Cong. Rec. 5002 (1974).

Such a reading not only flies in the face of the maxim of statutory construction that no part of a law is superfluous, *United States* v. *Menashe*, 348 U.S. 528 (1955), but also reveals an internal inconsistency in appellants' argument. If, as the insurers argue, the legislative history reveals that all non-federal regulation that relates to employee benefit plans is preempted, why do appellants argue that *certain* state insurance regulations are valid? (*See* Metropolitan Brief at 11).

In fact, the legislative history reveals that by means of the broadened preemption, Congress primarily sought to make clear that states could not regulate or prohibit prepaid legal services plans. Appellants obscure this purpose by shortening the quotes from Senator Williams and Representative Dent that they reproduce in their brief. (*See* Metropolitan Brief at 14-15). For example, Senator Williams really said:

> It should be stressed that with the narrow exceptions specified in the bill, the substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans. This principle is intended to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of law. *Consistent with this principle, state professional associations acting under the guise of State-enforced professional regulation, should not be able to prevent unions and employers from maintaining the types of employee benefit programs which Congress has authorized — for example, prepaid legal services programs — whether closed or open panel — authorized by Public Law 93-95. . . .*

120 Cong. Rec. 29933 (1974) (emphasis added).[13]

[13] Both Pfennigstorf and Turza agree that the broadened preemption language was a response by Congress to pressure from labor and consumer lobbies who wanted to experiment with prepaid legal service plans and also a reaction to 1974 actions by the American Bar Association relating to participation. *See* Turza & Holloway, *Preemption of State Laws Under ERISA*, 5 Pension Planning & Compliance 361, 365, 458 (1979) (hereinafter Turza); Pfennigstorf at 802-803, 829.

Interestingly enough, the then associate counsel of Appellant Travelers Insurance Company agreed with this view. *See* Okin, *Federal Preemption of State Law Under ERISA: An Examination of the Effects of the Federal Mandate in the Light of Authoritative Precedent Under the Supremacy Clause, the McCarran-Ferguson Act and the Legislative History*, 24 A. of Life Ins. Couns. Proc. 115, 149 (1976).

Likewise, Representative Dent explained that the broadening of ERISA's general preemption clause was intended to prohibit the states from prohibiting prepaid legal service plans. He analogized ERISA's preemption scheme to the preemption scheme in the Health Maintenance Organization Act:

> Finally, I wish to make note of what is to many the crowning achievement of this legislation, the reservation to Federal authority of the sole power to regulate the field of employee benefit plans. With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation. We followed to a large extent the same approach as in Public Law 93-222, 98 statute (414) where the regulation of health maintenance organizations was foreclosed to State authority — Section 113(a).
>
> The conferees, with the narrow exceptions specifically enumerated, applied this principle in its broadest sense to foreclose any non-federal regulation of employee benefit plans. *Thus, the provisions of Section 514 would reach any rule, regulation, practice or decision of any State, subdivision thereof or any agency or instrumentality thereof — including any professional society or association operating under code of law — which would affect any employee benefit plan as described in Section 4(a) and not exempt under Section 4(b).*

120 Cong. Rec. 29197 (1974) (emphasis supplied).[14]

[14] And to leave no doubt as to the meaning of the broadened preemption, Senators Taft, Javits, and Williams engaged in an extended colloquy in which

The HMO preemption scheme prohibits the states from regulating who can be providers of medical services in a health maintenance organization. *See* 42 U.S.C. § 300e-10, U.S. Code Cong. & Ad. News 3057-3058 (1973). Thus, Congressman Dent's analogy makes even clearer that he sought to prevent Congress from creating an ERISA preemption scheme that would allow the states to bar lawyers from participating in prepaid legal services plans.

Obviously, the broadening of the general preemption clause speaks to the breadth of ERISA's general preemptive effect, but to argue, as appellants do, that the broadening somehow narrows and obviates the insurance savings clause is disingenuous at best, and in light of the legislative history, deliberately misleading at worst.

Ordinarily, subsequent legislative history must be viewed cautiously as a barometer of legislative intent in enacting a particular statute. *Consumer Product Safety Comm.* v. *GTE Sylvania, Inc.*, 447 U.S. 102, 117 (1980). In certain circumstances, however, it can be "virtually conclusive," *Sioux Tribe of Indians* v. *United States*, 316 U.S. 317, 329-330 (1942), and entitled to great weight. *Red Lion Broadcasting Co.* v. *F.C.C.*, 395 U.S. 367, 381 (1968). This is such an unusual case. Here, events beginning in 1977 and culminating with passage of the ERISA Improvement Act of 1979 shed considerable light on the intent of Congress.

In 1977, Congress, as contemplated by §§ 3021 and 3022 of ERISA, 29 U.S.C. §§ 1221-1222, which established the Joint Pension Task Force, reviewed the effects and desirability of "federal preemption of state and local law with respect to pensions and similar plans." 29 U.S.C. § 1222(a)(5). The resulting study confirms that Congress intended to bar the states from continuing to regulate employee benefit plans but to allow the states to continue to regulate insurance and those

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they each emphasize that the states may not regulate prepaid legal service plans by mandating open or closed panels but may continue to enforce ethical rules. *See* 120 Cong. Rec. S. 15757-S.15758 (daily ed. Aug. 22, 1974).

who sell it. Activity Report of House Comm. On Education and Labor, H.R. Rep. No. 1785, 94th Cong., 2d Sess. 48 (1977).

That Congress viewed insurance as not subject to the federal act is emphasized in the Report by the lengthy discussion of insurance "entrepreneurs" who had begun to market insurance products but claimed that such products were employee benefit plans and therefore sheltered from regulation by state insurance laws.

> It has come to our attention . . . that certain entrepreneurs have undertaken to market insurance products to employers and employees at large, claiming these products to be ERISA covered plans . . . . The entreprenuer will then argue that his enterprise is an ERISA benefit plan which is protected, under ERISA's preemption provision, from state regulation. . . . [T]hese plans are established and maintained by entrepreneurs for the purpose of marketing insurance products or services to others. They are not established or maintained by the appropriate parties to confer ERISA jurisdiction. . . . *They are no more ERISA plans than is any other insurance policy sold to any employee benefit plans. To the extent that such programs fail to meet the definition of 'employee benefit plan' state regulation of them is not preempted by Section 514, even though such state action is barred with respect to the plans which purchase these 'products.'*

Activity Report of House Comm. On Education and Labor, H.R. Rep. No. 1785, 94th Cong., 2d Sess. 48, 49 (1977) (emphasis supplied). Thus, the Oversight Task Force recognized and confirmed the distinction in ERISA so criticized by appellants, namely that states may regulate insurance products purchased by employee welfare plans, but may not regulate the plans themselves. Indeed, the Report went so far as to urge state insurance commissioners "to take appropriate action to prevent the continued wrongful avoidance of proper state regulation of these entities." *Id.*

While the Task Force was completing its work, the First Circuit Court of Appeals decided *Wadsworth* v. *Whaland*, 562 F.2d 70 (1st Cir. 1977), *cert. denied*, 435 U.S. 980 (1978). The rationale underlying the decision was entirely consistent with the Report. Indeed, in his brief to this Court opposing *certiorari*, the Solicitor General articulated the premise now advanced by the Commonwealth in the following terms:

> [t]he fact that the purchaser of insurance is an employee benefit plan is immaterial; Congress did not intend to confer any special exemption or privilege on them as insurance buyers.

Memorandum for the United States as Amicus Curiae On Petitions for Writs of Certiorari at 8, *Wadsworth* v. *Whaland*, 562 F.2d 70 (1st Cir. 1977), *cert. denied*, 435 U.S. 980 (1978).

After this Court denied certiorari in 1978, Congress was promptly confronted with an attempt to overturn the First Circuit's holding that a state mandated benefit law, similar to § 47B, was immune from preemption by virtue of the savings clause. The vehicle for such a change was a proposed redefinition of insurance in 29 U.S.C. § 1144(b)(2)(A):

> A state insurance law which provides that a specific benefit or benefits must be provided or made available by a contract or policy of insurance issued to an employee benefit plan is a law which relates to an employee benefit plan within the meaning of subsection (a), [the general preemption clause], and is not a law which regulates insurance within the meaning of subparagraph (A) [the insurance savings clause].

S. 209, 96th Cong., 1st Sess. § x (1979).

This attempt to amend ERISA failed. *Id*. *See* U.S. Sen. Comm. on Labor and Human Resources, *The ERISA Improvement Act of 1979*: *Summary and Analysis of Consideration*,

46, 88 (1979); *see also* 125 Cong. Rec. 931, 937 (1979); and Turza at 465-467.

Under these unique circumstances, the fact that Congress did not amend the insurance savings clause when it knew mandated benefit laws were being sheltered from preemption by virtue of ERISA's savings clause for state insurance laws is "virtually conclusive" evidence of the Commonwealth's view that Congress intended such state regulation to continue. If the appellant insurance companies disagree with the policy underlying that decision, their recourse is again to Congress

4. The Historical Background — As It Reflects On The Purposes of ERISA.

Nothing in the historical background of ERISA supports a departure from the plain language of the insurance savings clause and its legislative history. ERISA's preeminent purpose is pension regulation.[15] Welfare plans[16] receive much less attention in ERISA.[17] For the same reasons that eventually led Congress to enact ERISA in 1974, Massachusetts and several other states passed laws in the 1950's regulating employee welfare plans and pension plans.[18] Long before ERISA was

[15] The major reason for pension reform was the scandalous loss of pensions due to fraud and abuse by unions and pension trustees. 29 U.S.C. §§ 1301-1309. For a history of pension plan regulation see, S. Rep. No. 127, 93d Cong. (1974), reprinted in U.S. Code Cong. & Ad. News 4838, 4839.

[16] An employee welfare benefit plan is described as one which provides "medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability or death . . . whether the benefits are provided *through the purchase of insurance* or otherwise. 29 U.S.C. § 1001 (a)(A) (emphasis supplied).

[17] Welfare plans, for example, are subject to the reporting and disclosure standards of Title I, but exempt from the participation, vesting and funding standards established for pension plans. 29 U.S.C. §§ 1051(1), 1081(a)(1). Most of the legislative history and reports concern pension plans. Pfennigstorf at 791 n.21.

[18] 1958 Mass. Acts. c. 655, codified at Mass. G.L. c. 151D. Chapter 151D was repealed and re-created by 1973 Mass. Acts, c. 1169. *See also* Wis. Stat. § 211.02(1) (1959); Pfennigstorf at 792-793; Turza at 370-371; *Malone* v. *White Motor Corp.*, 435 U.S. 497 (1978).

enacted state insurance laws also provided protection for employees, particularly insofar as they regulated insurance purchased to provide benefits for employee welfare plans.[19]

In addition, several of the states attempted to regulate employee welfare plans through state insurance laws by deeming employee welfare plans to be insurers or insurance companies.[20] One motivation for states to deem employee benefit plans to be insurers was that employers in the 1950's had begun to "self-insure" rather than purchase insurance benefits from commercial insurers in order to obtain substantial savings in the decreased state premium taxes and IRS taxes.[21]

By deeming employee welfare plans to be insurers the states preserved state taxing power,[22] and provided protection to employees. Such state regulation raised the possibility of conflict with existing federal law including the Internal Revenue Code and the Taft-Hartley Act of 1947. Pfennigstorf & Kimball, *Employee Legal Service Plans: Conflicts Between Federal and State Regulation,* 1976 A.B. Found. Research J. 787, 793 (hereinafter Pfennigstorf). It is against this background of scandal and a patchwork of federal and state regulation of welfare and pension plans that Congress enacted ERISA on Labor Day in 1974. And, with knowledge of this patchwork of federal and state regulation, Congress deliberately and explicitly chose

[19] Welfare plans first developed informally as employers occasionally paid the medical and hospital bills of ill workers. In approximately 1910, insurance companies started to sell group insurance plans to employers. Finally, in 1930, Blue Cross and Blue Shield developed, and from that point on broad welfare plans evolved. Turza at 367 n.32.

[20] Turza at 371; Pfennigstorf at 795-796. *See generally* Goetz, *The Regulation of Uninsured Employee Welfare Plans Under State Insurance Laws,* 1967 Wis. L. Rev. 319. This so-called "deeming" is the historical reason that led Congress in ERISA to specifically prohibit such deeming. 29 U.S.C. § 1114(b)(2)(B).

[21] *See* Pfennigstorf at 795; Turza at 371. The appellants ignore the history of self-insurance and the trial court's findings of fact (J.S. App. 55a) and claim that mandating benefits leads to self-insurance. (Metropolitan Brief at 30). In fact, financial interests of employers often argue for self-insurance, and the profit motive of insurers argues against it. *See generally,* 1963 Vol. I *NAIC Proceedings* 76.

[22] *Id.*

to preserve the ability of states to regulate insurance. As demonstrated below, that authority unquestionably includes the power to mandate the policy terms between the insured and the insurer.[23]

C. *Section 47B is a State Insurance Law.*

It remains only to demonstrate that § 47B is a law which regulates insurance within the meaning of ERISA to complete the analysis.

The insurers argue strenuously that § 47B is not a "traditional" insurance law and hence is not protected by the savings clause for state insurance laws. They assert that laws which control the content of insurance policies, such as § 47B, were not what Congress had in mind when it saved state insurance laws from preemption (Metropolitan Brief at 34).

But the insurers' argument is fatally flawed in two basic respects: first, it ignores the long history of this Court's decisions holding that the states may control the content of insurance policies; second, it ignores the absurd result of insurers' argument, that is, the creation of a regulatory vacuum if state insurance laws such as § 47B, and others identical in nature to § 47B, are preempted but not replaced by a federal regime.

[23] It is indisputable that numerous mandated benefit laws, including Massachusetts', existed prior to ERISA's enactment, including in at least seven states statutes that mandated some form of mental illness benefit. *See* Ariz. Rev. Stat. Ann. § 20-1402(4)(b) (West Supp. 1983-1984) (enacted 1971); Conn. Gen. Stat. Ann. § 38-174d (West Supp. 1984) (enacted 1971); Ill. Ann. Stat. c. 73, § 979(7) (Smith-Hurd Supp. 1983-1984) (enacted in 1972); Mass. Gen.Laws c. 175, § 47B (enacted in 1973); Md. Ann. Code art. 48A, § 477E (Michie Supp. 1983) (enacted in 1973); Minn. Stat. Ann. § 62A.149 (West Supp. 1984) (enacted in 1972); 1971 Wis. Laws c. 325 (enacted in 1971). *See also,* Metropolitan Jurisdictional Statement at 8-9 n.5; Brief of Health Insurance Association of America as Amicus Curiae In Support of Jurisdictional Statements in this case at Appendices, September, 1984. Presumably, these and all other insurance laws which control the content of insurance policies would fall to preemption under the insurers' analysis.

1. Mandating Benefits and Controlling the Content of Insurance Policies is a Traditional Function of State Insurance Laws.

In *SEC* v. *National Secur., Inc.*, 393 U.S. 453 (1969), this Court explained that the "core" of insurance regulation consisted of affecting "[t]he relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement. . . . Statutes aimed at protecting or regulating this relationship [between the insurance company and the policyholder], directly or indirectly, are laws regulating the business of insurance." *Id.* at 460. This Court has also held that state insurance commissioners have "full power to prescribe the forms of contracts [and] the terms of protection of the insured." *Hoopeston Canning Co.* v. *Cullen*, 318 U.S. 313, 321 (1943). This Court has also held that the "spreading and underwriting of a policyholder's risk" are the "primary elements" of insurance. *Group Life & Health Ins. Co.* v. *Royal Drug Co.*, 440 U.S. 205, 211 (1979). Despite this recognition that control of the content of insurance contracts is a traditional part of insurance regulation, insurers argue that "state laws whose purpose and effect is to control plan content" are not insurance laws (Metropolitan Brief at 34). Hence, we delve further into the question of what insurance laws are.

2. Section 47B, Like Myriad State Insurance Laws, Functions to Spread the Risk and Control the Cost of Insurance and Thereby Make Coverage Accessible.

Appellants assert that because § 47B "seek[s] to improve access to mental health care" and "make mental health care more readily available to all state residents," § 47B is not an insurance law, but instead an invalid attempt to control the content of employee benefit plans and destroy the voluntary selection of benefits by employers and employees (Metropolitan Brief at 22-23). In light of the history of state regulation of insurance content and this Court's validation of the same, it is no surprise that the insurers cannot drum up even one

citation for their "content" neutrality and voluntary market arguments.

Massachusetts, for example, has a long history of regulating the content of insurance policies. As early as 1908, Massachusetts prescribed mandatory provisions for insurance policies. *New York Life Ins. Co.* v. *Hardison*, 199 Mass. 190, 85 N.E. 410 (1908). Since 1956, Massachusetts has required all group life insurance policies to include a provision ensuring that any insured who leaves the group shall remain insured by the policy for a certain time period, unless the insured is otherwise entitled to similar benefits. Mass. Gen. Laws c. 175, § 134(4). In 1967, the legislature required that all group health insurance policies contain a similar provision. Mass. Gen. Laws c. 175, § 110D. In the area of automobile insurance, in particular, Massachusetts mandates both the kinds of policies which insurers must offer to sell and the kinds of coverage which insureds must purchase. *See* Mass. Gen. Laws c. 175, §§ 113 *et seq.* There is essentially no voluntary market for automobile insurance in Massachusetts. In 1969, the legislature established specific amounts of compulsory automobile liability insurance, and also required that all automobile insurance policies include coverage for damages caused by uninsured motorists. Mass. Gen. Laws c. 175, §§ 113C, 113L.

Conceptually, there is no distinction between mandatory minimum auto insurance and mandatory minimum mental illness benefits. Even the insurers do not argue that auto insurance is not traditional, yet under their analysis, automobile insurance laws would fall to preemption if auto insurance were offered as a welfare plan benefit. *See California Auto Association* v. *Maloney*, 341 U.S. 105 (1951) (state law upheld requiring insurers to participate in a mandatory assigned risk pool to assure the availability of auto insurance). Such an absurd result highlights the poverty of the insurers' "traditional" and "non-traditional" distinction and the weakness of their content neutrality argument.

Massachusetts is not alone in regulating the content of insurance policies or the relationship between insureds and insurers. In *Wayne Chemical, Inc.* v. *Columbus Agency Service Corp.*,

426 F. Supp. 316 (1977), *aff'd*, 567 F.2d 692 (7th Cir. 1977), the district court, adopting the First Circuit's analysis in *Wadsworth* v. *Whaland*, 562 F.2d 70 (1st Cir. 1977), *cert. denied*, 435 U.S. 980 (1978), upheld a law that imposes on insurers who write health insurance the requirement that insurers extend the major medical coverage of dependents who are disabled at the time they reach the limiting age of the policy. The district court noted that at least twenty-five states had such mandatory benefit laws. *Wayne Chemical, Inc.* v. *Columbus Agency Service Corp.*, 426 F. Supp. at 324 n.8. Under the insurers' analysis, all these mandated benefit laws would fall under the Supremacy Clause.

Yet many of these mandated benefit laws have already withstood judicial scrutiny. In *Insurers' Action Council, Inc.* v. *Markman*, 653 F.2d 344 (8th Cir. 1981), for instance, the Circuit Court upheld a mandated mental health benefits law. Similarly, in *Health Ins. Ass'n of America* v. *Harnett*, 44 N.Y.2d 302, 376 N.E. 2d 1280 (1978), the court sustained a law mandating the provision of maternity benefits based on the clear authority of the state legislature to regulate insurance companies. *See American Family Life Assur. Co.* v. *Commissioner of Ins.*, 388 Mass. 468, 446 N.E.2d 1061 (1983) (validity of Massachusetts regulation controlling the content of insurance policies by banning the sale of policies that provide benefits only for cancer); *see also Blue Cross of Virginia* v. *Commonwealth*, 221 Va. 349, 269 S.E.2d 827 (1980); *American Progressive Life & Health Ins. Co.* v. *Corcoran*, 715 F.2d 784 (2d Cir. 1983); *Wayne Chemical, Inc.* v. *Columbus Agency Service Corp.*, 567 F.2d 692 (7th Cir. 1977); *Wadsworth* v. *Whaland*, 562 F.2d 70 (1st Cir. 1977), *cert. denied*, 435 U.S. 980 (1980). In addition, the Solicitor General, representing the Department of Labor, has taken the position that mandated benefit laws are not preempted by ERISA. *See* Memorandum of the United States As Amicus Curiae On Petitions For Writs of Certiorari, *Wadsworth* v. *Whaland, supra*. Such virtual unanimity highlights the intellectual bankruptcy of insurers' arguments.

3. The Insurers' Arguments About the Effect of § 47B on Employee Benefit Plan Administration are Fatally Flawed.

Appellants argue that an underlying goal of Congress in ERISA was "to leave the substantive content of employee welfare and pension plans to private determination" (Metropolitan Brief at 27). Insurers also assert that by obviating free choice of benefits and promoting nonuniformity from state to state, mandated benefit laws create disturbing distinctions between insured and uninsured plans — distinctions that Congress did not intend. Insurers also contend that mandated benefit laws increase costs and encourage employee benefit plans to self-insure.

These arguments ignore several facts. First, ERISA itself is notably silent as to the content of welfare plans. Second, there is no evidence that Congress did not intend the distinction between insured and uninsured plans that so troubles appellants. Indeed, as discussed at 24-27, subsequent legislative history makes clear that Congress is cognizant that because of the insurance savings clause, state insurance laws affect and control part of the content of insured plans, while uninsured plans operate without regard to state insurance laws.

The insurers' uniformity argument suffers from one major and quite obviously fatal flaw: the national status-quo, without regard to this case, is that multitudinous nonuniformities from state to state exist in insured employee benefit plans. By accepting state insurance laws, Congress accepted that variations from state to state would exist in employee welfare plans. And, as the trial judge found "there is no credible evidence that [the diversities created by mandated benefit laws] are any more complex or burdensome to interstate commerce than various other diverse multi-state regulatory schemes such as workmen's compensation laws." (J.S. App. 56a.) In addition, this Court in *Shaw* has already upheld an exception to ERISA preemption for state disability laws that also results in national nonuniformity. *Shaw* v. *Delta Airlines, Inc.*, 103 S.Ct. at 2906.

The cost arguments of the insurers actually distort the cost impact of mandated benefit laws. Insurers argue against the express findings of the trial court that mandated benefit laws increase the cost of insurance; The Health Insurance Association of America, Amicus Curiae on Behalf of Appellants, alleges, without citation, a 20% increase in cost (Metropolitan Brief at 23-26); (Brief of Health Insurance Association of America as Amicus Curiae at 7). In fact, by eliminating "adverse selection," mandated benefit laws actually spread the cost of mental illness insurance among all insureds and insurance companies (J.S. App. 50a-51a). Such spreading of the risk and cost is a fundamental purpose of insurance laws in general and mandated benefit laws in particular. *SEC* v. *National Secur., Inc.*, 393 U.S. at 460; (A. 225).

In the same manner, insurers have been notably unable to produce any proof, now or at trial, that mandated benefit laws contribute to the trend toward self-insurance. Several commentators have suggested that the savings in state and federal taxes associated with self-insurance, as well as the obvious savings of insurers' profit margin, are the underlying rationale for the general trend toward self-insurance. *See* Turza & Holloway, *Preemption of State Laws Under ERISA*, 5 J. Pension Planning & Compliance, 361, 371 (1979); Pfennigstorf at 795. While it may be intuitatively attractive to argue that a mandated benefit law encourages self-insurance, insurers simply have no evidence to support such an argument. In any event, such policy arguments should be addressed to Congress, not this Court.[24]

II. Section 47B Is Not Preempted by the NLRA Because it Does Not Conflict with the Policy or Purposes of Federal Labor Law.

The standard for preemption of a state statute by the NLRA is no different from that used to determine preemption of state

[24] Indeed, the trial judge found that there was no credible evidence that the trend toward self-insurance was more pronounced in Massachusetts because of § 47B and that the 'trend' "has permeated various types of insurance mechanisms due to sharply escalating prices for various types of insurance coverage. . . . examples include health, product liability and professional liability insurance" (J.S. App. 55a).

law by ERISA: "the purpose of Congress is the ultimate touchstone." *Malone* v. *White Motor Corp.*, 435 U.S. 497, 504 (1978), quoting *Retail Clerks International Association* v. *Schermerhorn*, 375 U.S. 96, 103 (1963). While the standard is the same, the level of guidance given by Congress to determine whether state law is superseded by the NLRA is far less than that provided by Congress in ERISA. *See Brown* v. *Hotel & Restaurant Employees & Bartenders International Union Local 54*, ___ U.S. ___, 104 S. Ct. 3179, 3185 (1984). Unlike ERISA, the NLRA contains no provision whatsoever for how state or, for that matter, federal law interacts with it. *See Garner* v. *Teamsters Union*, 346 U.S. 485, 488 (1953).

What is clear about state law preemption under the NLRA is that Congress did not intend that the states be precluded from continuing to exercise their police powers. *Allen-Bradley Local* v. *Wisconsin Employment Relations*, 315 U.S. 740, 749 (1942). Local regulation will be sustained unless it conflicts with federal law or frustrates the federal scheme. *Malone* v. *White Motor Corp.*, 435 U.S. at 504. This Court has recognized that it "cannot declare preempted all local regulation that touches or concerns in any way the complex interrelationships between employees, employers and unions; *obviously, much of this is left to the states*." *Motor Coach Employees* v. *Lockridge*, 403 U.S. 274, 289 (1971) (emphasis supplied). Instead, conflict exists when, by virtue of the operation of the state statute, the purpose of the federal act cannot be accomplished. *Hines* v. *Davidowitz*, 312 U.S. 52, 67 n.20 (1941).

The purpose of the NLRA is also abundantly clear. The declared policy of Congress is to encourage the process of collective bargaining between labor and management and thereby to promote the overall design of achieving industrial peace and eliminating obstruction to the free flow of commerce. 29 U.S.C. § 151; *see NLRB* v. *Jones & Laughlin Steel Corp.*, 301 U.S. 1, 45 (1937). It is equally clear that the negative implications of the Commerce Clause have no bearing on state insurance laws. With the McCarran-Ferguson Act, Congress

effectively eliminated such implication. *Western & Southern Life Ins. Co.* v. *State Bd. of Equalization*, 451 U.S. 648, 656 (1981) (Commerce Clause is inapplicable to the business of insurance).

Section 47B, governing only the types of health insurance policies which may be issued in Massachusetts and sold to the general public, which includes labor and management, is an example of a law which is properly left to the police power of the states. It does not conflict with the expressed federal labor law policy and, therefore, withstands the insurers' challenges to its preemption by the NLRA.

A. *Section 47B Is Not Preempted by the NLRA Because it Regulates the Types of Insurance Policies Issued in Massachusetts and Does Not Regulate Substantive Terms of Collective Bargaining Agreements.*

1. Examination of § 47B.

In order to determine whether § 47B is preempted by the NLRA, its purpose and function must be assessed to determine the existence of conflict with the federal law or policy. There can be no question that the Massachusetts legislature adopted § 47B to address problems associated with mental health treatment in the Commonwealth (A. 426-458). Treatment was generally unavailable to those needing it because they could not afford the cost. The treatment which was provided was on a state-subsidized, institutionalized basis and thought by many to be draconian (A. 430-432). Recognizing that the retracted state of the voluntary mental health insurance market due to adverse selection was at the root of the state's mental health treatment problems, the legislature enacted § 47B. It was designed to correct the market, spread the risk of covering so-called "bad risks" to all insurance companies issuing accident and sickness policies, support the financing of community mental health treatment centers across the state, and reduce the number of persons receiving treatment in state mental institutions — all to achieve the ultimate goal of improving mental

health care in the Commonwealth[25] (*see* Statement of the Case, at 2-6 *supra*).

Because the purpose of § 47B is to improve the perceived inadequacies of treatment of mental illness in Massachusetts stemming from the unavailability of adequate benefits coverage and the financial inability of people who needed the coverage to buy it, the function of § 47B is marked by its singular focus on insurance policies and their market. Section 47B is a law of general application which regulates the types of accident and sickness insurance policies that may be issued and sold to anyone in Massachusetts. It requires only that such policies must provide coverage for Massachusetts residents in accordance with the minimum benefits set forth in the statute.[26]

Section 47B is not, by any standard, an attempt to affect the collective bargaining process, nor is it aimed at dictating the substantive terms which must be a part of collective bargaining agreements. *See Massachusetts Nurses Ass'n* v. *Dukakis*, 726 F.2d 41 (1st Cir. 1984). Rather, it implements a broad public policy with respect to treatment of mental illness in the Commonwealth, without concern for the dynamics of labor-management relations. *New York Tel. Co.* v. *New York State Dept. of Labor*, 440 U.S. 519, 534 (1979). The product of collective bargaining, as dictated by the NLRA, remains a function of the relative strengths of the parties to the agreement.

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[25] The trial judge found that without enactment of § 47B, the economics of health insurance would make it difficult, if not impossible, to provide effective mental health insurance coverage (J.S. App. 50a); *see* T. McGUIRE, FINANCING PSYCHOTHERAPY, Ballinger Publishing Co. (1981) at 50; Sharfstein, "Dispelling Myths About Mental Health Benefits," Business and Health, Oct., 1984.

[26] As a statute of general application, § 47B must be viewed in light of this Court's repeated acknowledgments that "a congressional intent to deprive the states of their power to enforce such general laws is more difficult to infer than an intent to preempt law directed specifically at concerted activity." *New York Tel. Co.* v. *New York State Dept. of Labor*, 440 U.S. at 544; *Farmer* v. *United Brotherhood of Carpenters & Joiners*, 430 U.S. 290, 302 (1977); *Sears, Roebuck & Co.* v. *San Diego County Dist. Council of Carpenters*, 436 U.S. 180, 194-195 (1978). Indeed, it has been suggested that when a state statute of general application is at stake, the burden to show congressional intent to preempt the state law rests with the party seeking to escape its effects. Cox, *Recent Developments in Federal Labor Law Preemption*, 41 Ohio St. L. J. 277, 293 (1980).

The appellants' claim that § 47B impermissibly imposes conditions on collective bargaining agreements misconstrues the operation of § 47B and its effect. By simply limiting the forms of accident and sickness policies which may be purchased in the Commonwealth, § 47B applies only if insurance is purchased, and even then, the statute imposes its terms on labor and management alike, without in any way favoring or burdening either party. *NLRB* v. *Insurance Agents' International Union*, 361 U.S. 477, 490 (1960). The relative strengths of the parties to collective bargaining remain unaffected by § 47B's requirement that all accident and sickness policies issued in the state include the prescribed benefits. Likewise, the multitude of solutions which are possible to settle the parties' differences regarding wages, hours and terms and conditions of employment remain unaffected. The requirements of § 47B, which must be a part of any health insurance plan, are no more a burden on or interference with collective bargaining than state laws requiring that employers contribute to unemployment and workmen's compensation funds, laws prescribing mandatory state holidays, or those dictating payment by employers to employees for time spent at the voting polls or on jury duty. *West Coast Hotel Co.* v. *Parrish*, 300 U.S. 379 (1937) (minimum wages); *Mountain Timber Co.* v. *Washington*, 243 U.S. 219 (1917) (workmen's compensation); *Day-Brite Lighting, Inc.* v. *Missouri*, 342 U.S. 421 (1952), *reh. den.*, 343 U.S. 921 (payment to employees while voting).

Contrary to the actual method of operation of § 47B, the appellants would have this Court believe that § 47B requires collective bargaining agreements themselves to contain certain statutorily prescribed terms. The examination of § 47B's purpose and method of operation makes all too clear, however, just how attenuated § 47B's effect on collective bargaining actually is. As this Court recognized in *Malone*, preemption is required only if "the congressional intent to do so is *implied* from the relevant provisions of the labor statutes." *Malone* v. *White Motor Corp.*, 435 U.S. at 505 (emphasis in original). But there is nothing in the NLRA which, even by implication,

can be said to evidence a congressional intent to preempt a state law which mandates the types of accident and sickness insurance policies which can be issued within a state.

2. Federal Labor Law Preemption.

Without deviating from the preemption standard which presumes the validity of state law unless the purpose of the federal act cannot be accomplished, congressional intent to preempt under the NLRA has historically been implied in matters involving two kinds of state regulation. *Belknap, Inc.* v. *Hale*, 463 U.S. 491, 103 S. Ct. 3172, 3176-3177 (1983). The first covers conduct which is actually or arguably either protected or prohibited by the Act. Such conduct has been found, with some exceptions, to come under the primary jurisdiction of the NLRB and state attempts to regulate or adjudicate it are preempted. *San Diego Bldg. Trades Council* v. *Garmon*, 359 U.S. 236, 245 (1959). This branch of the preemption analysis is clearly not implied by § 47B, as the NLRA is admittedly silent on the matter of the forms of insurance policies which may be issued in the state.[27]

The second NLRA preemption doctrine covers conduct involving the availability to unions and employers of self-help measures which the state has attempted to regulate or adjudicate, thereby potentially altering the parties' economic relationship, but which Congress intended be left unregulated. *International Ass'n of Machinists & Aerospace Workers* v. *Wisconsin Employment Relations Comm'n*, 427 U.S. 132, 147-148 (1976) (*Machinists*). Such state regulation or adjudication is

[27] The exceptions to preemption under this doctrine include state regulation or adjudication over conduct which is of "only peripheral concern to the federal law" or "touches interests deeply rooted in local feeling and responsibility." *Id.* at 243-244. In such cases, the state interest in regulating or adjudicating the conduct in question is balanced against the federal interest in protecting the NLRB's ability to adjudicate controversies committed to it by the Act, *Belknap, Inc.* v. *Hale*, 463 U.S. 491, 103 S. Ct. 3172, 3177 (1983); and one cannot make the "easy inference that Congress intended to deprive the States of their ability to retain jurisdiction over such matters." *Brown* v. *Hotel & Restaurant Employees & Bartenders International Union*, 104 S. Ct. 3179, 3187 (1984).

preempted because it can frustrate effective implementation of the processes prescribed by the NLRA. *Id.* But despite the appellant's mistaken assertions that preemption under the *Machinists* doctrine admits of no exceptions, (*see* Travelers Brief at 11, 26), state regulation is not preempted under the *Machinists* doctrine in instances in which Congress has demonstrated an intent that states are required or permitted to regulate in such areas. *New York Tel. Co.* v. *New York State Dept. of Labor*, 440 U.S. 519; *Brown* v. *Hotel & Restaurant Employees & Bartenders International Union*, 104 S. Ct. 3179; *Malone* v. *White Motor Corp.*, 435 U.S. at 497.[28]

The appellants press a significantly expanded view of preemption under the *Machinists* doctrine by seeking to apply it to § 47B. Relying on an earlier case, *Teamsters Union* v. *Oliver*, 358 U.S. 283 (1959), they maintain that Congress intended that "activity to be left unregulated" include not only the methods or processes by which collective bargaining is undertaken, but also the substantive terms of collective bargaining agreements, and by logical extension, the regulation of employment conditions generally. Yet there is no indication that Congress indeed intended to preempt state activity unrelated to the collective bargaining process, or as appellants have suggested, to permit unions and employers together to agree to collective bargaining terms which, because of state law, employers would be prohibited from establishing unilaterally. Congress demonstrated no intent that the NLRA or the collective bargaining process be used as a refuge by employers seeking to avoid compliance with state laws which they perceive as burdensome or as an engine to override state insurance laws. Cox, *Recent Developments in Federal Labor Law Preemption*, 41 Ohio St. L. J. 277, 297 (1980). Congress' concern in developing federal labor law policy is and always has been with the *process* of establishing the terms and condi-

[28] It is also not preempted in instances in which the *Garmon* exception of protecting interests "deeply rooted in local feeling and responsibility" may be applied by analogy. *New York Tel. Co.* v. *New York State Dept. of Labor*, 440 U.S. at 539-540.

tions of employment, not in prohibiting state prescriptions of such terms. This Court's decisions reflect that fact.[29]

Given Congress' concern only with the methods by which collective bargaining is undertaken, it is clear that this case is not a *Machinists* preemption matter. Cases under that doctrine uniformly involve the use of an economic weapon in the collective bargaining process, as the party against whom the weapon is used seeks to eliminate its availability to the other. *Teamsters, Chauffeurs & Helpers Union* v. *Morton*, 377 U.S. 252 (1964), the first "*Machinists*-type" case, concerned the union's use of secondary boycotting as a means to induce management to come to an agreement with it. The *Machinists* case itself, involved the union's concerted refusal to work overtime. *New York Tel. Co.* involved payment of unemployment compensation benefits to strikers, and *Brown* v. *Hotel and Restaurant Employees* concerned the removal of union representatives from positions of authority within the union. These cases turn on the notion that:

> To sanction state regulation of such economic pressure deemed by the federal Act 'desirabl[y] . . . left for the free play of contending economic forces, . . . is not merely [to fill] a gap by outlaw[ing] what federal law fails to outlaw; it is denying one party to an economic contest a weapon that Congress meant him to have available.'

International Ass'n of Machinists & Aerospace Workers v. *Wisconsin Employment Relations Comm'n*, 427 U.S. at 150, quoting Lesnick, *Preemption Reconsidered: The Apparent Reaffirmation of Garmon*, 72 Col. L. Rev. 469, 478 (1972).

The appellants' preemption analysis is thus limited to *Oliver*. That case, however, involved the validity of a collective bargaining agreement term setting the rates of truck rentals paid to union truck drivers driving their own trucks in light of

[29] As is discussed in the next section of this brief, states have always been free to regulate the terms and conditions of employment within their borders. *See, e.g., De Canas* v. *Bica*, 424 U.S. 351 (1976) (state statute prohibiting employer from knowingly employing an illegal alien, if such employment would have adverse effect on lawful resident workers, is not preempted); *Day-Brite Lighting, Inc.* v. *Missouri*, 342 U.S. 421 (1952), *reh. den.*, 343 U.S. 921 (state statute requiring employer to pay employees during hours in which employees go to voting polls is constitutional).

Ohio's antitrust law proscribing the setting of such rental rates by collective bargaining. The Court held that the antitrust law could not displace that provision of the bargaining agreement, stating that "there is no room in this [federal labor] scheme for the application here of this state policy limiting the solutions that the parties' agreement can provide to the problems of wages and working conditions." *Oliver*, 358 U.S. at 296. But the *Oliver* holding is distinguishable from the case of § 47B in several significant respects.

First, the Court in *Oliver* was directly concerned with the methods by which the rental rates could be established. *Id.* at 294-295; Cox, *Recent Developments in Federal Labor Law Preemption*, 41 Ohio St. L.J. at 298. Federal labor law prescribed the setting of such rates through collective bargaining, while the state antitrust law prohibited ratesetting in that manner because it amounted to monopolization. Thus, it was the process, not the proscription against requiring certain substantive terms in the agreement, which this Court identified as Congress' chief concern. Second, *Oliver* emphasized that the issue of rental rates was an integral part of the union's wage structure, not a "remote and indirect approach to the subject of wages," *id.* at 294, as is § 47B's effect on the terms and conditions of employment. Third, *Oliver* recognized exceptions to its holding; state law was not to be preempted if Congress did not so intend, *id.* at 296, or if the state regulation was adopted to protect the public's health or safety. *Id.* at 297.[30]

Unlike *Oliver*, § 47B affects neither the collective bargaining process nor the result. It is simply not "a 'state law regulating the relations between employees, their unions, and their employers' as to which the reasons underlying the preemption doctrine have their 'greatest force'." *New York Tel. Co.*, 440 U.S. at 533, quoting *Sears, Roebuck & Co.* v. *San Diego County Dist. Council of Carpenters*, 436 U.S. 180, 193 (1978). Rather, § 47B regulates the types of insurance policies issued in the state and addresses the problems of mental illness and its insurability, without in any way affecting the relative strengths or economic relationships between labor and management. Sound principles of federalism require this Court to sustain its validity. *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. at 522.

[30] As the next section demonstrates, § 47B satisfies both such exceptions.

B. *Section 47B is Not Preempted Because the States May Regulate in Both the Mental Health and Insurance Areas.*

1. a. The State's Authority to Regulate Mental Health and Congress' Federal Policy.

Since the earliest days of the United States Constitution, this Court has recognized that the states have great latitude under their police powers to legislate as to "the protection of lives, limbs, health, comfort and quiet of all persons, and protection of all property within the state." *In re Slaughter-House Cases*, 83 U.S. 36, 62-63 (1873); *Beer Co.* v. *Massachusetts*, 97 U.S. 25, 32 (1878); *Commonwealth* v. *Alger*, 61 Mass. (7 Cush.) 53, 87-88 (1851). The regulation of public health has always been thought to be of particular local concern and responsibility. *Barsky* v. *Board of Regents*, 347 U.S. 442, 449 (1954) ("A state has broad power to establish and enforce standards of conduct within its borders regarding the health of everyone there and such power is a vital part of the states' police power.")

Given Congress' strong deference to the states in matters involving protection of public health, it is not surprising that in developing federal policy regarding mental health treatment, Congress has relied heavily on state activity.[31] Numerous federal laws have been enacted which have funded community mental health treatment centers, encouraged state plans in addressing health treatment problems, and promoted state participation in preventing mental illness generally.[32]

[31] There is an enormous unmet need in the United States for mental health treatment. *See generally*, 41 Archives of General Psychiatry, No. 10 (Oct. 1984). In a report to the National Institute of Mental Health, the authors of one article contained in volume 41 of the Archives of General Psychiatry estimate that 1 in 5 persons suffers from a diagnosable form of mental illness. Robins, *Lifetime Prevalence of Specific Psychiatric Disorders In Three Sites*, 41 Archives of General Psychiatry, 949, 952; *See* Wells, *Cost Sharing and The Demand For Ambulatory Mental Health Services*, Report of Rand Corporation and United States Department of Health and Human Services at 11, Library of Congress No. R. 2960 HHS (1982).

[32] The Community Mental Health Centers Act, P.L. 88-164, 77 Stat. 290, 42 U.S.C. §§ 2681 *et seq.*, was passed in 1963 and originally addressed prob-

Massachusetts, in confronting mental health issues in 1973, acted in conformance with federal policy when it perceived the need for state regulation through insurance. Massachusetts had anticipated congressional action to have taken the form of a national health insurance mandate, but when Congress failed to act, Massachusetts did not hesitate (A. 427). When Congress has been silent on matters it recognizes are within the purview of the states, it has always deferred to state law. *New York Tel. Co.* v. *New York State Dept. of Labor*, 440 U.S. at 544; *Silkwood* v. *Kerr McGee Corp.*, ___ U.S. ___, 104 S. Ct. 615, 623 (1984); *cf. Massachusetts Nurses Ass'n* v. *Dukakis*, 726 F.2d at 44.

There is little doubt that § 47B is a valid exercise of Massachusetts' police power which is consistent with Congress's policy on mental health care and, in effect, an expression of congressional mental health care policy. The Commonwealth has confronted the public health problems associated with mental health treatment by passing an insurance law aimed at ensuring the availability of affordable mental health treatment to everyone in the state. It has promoted the proliferation of community mental health centers in the state, which is a

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lems in treating mental retardation and other mentally-related illness and handicaps through the funding of community centers. The thrust of the law was to address treatment problems by coordinated national, state and local action. The funding was extended in 1975, P.L. 94-63, 89 Stat. 309, 42 U.S.C. §§ 2689 *et seq.* and later replaced in 1981 by block grants to the states. P.L. 97-35, 95 Stat. 560 (1981).

The National Health Planning & Resources Development Act of 1974, P.L. 93-641 § 2, 88 Stat. 2226 (1975), 42 U.S.C. §§ 300 k *et seq.*, encouraged the development of a federal policy with respect to health care generally and included extensive state participation in policy development as well. Section 300 k-2(a), subparagraphs (14), (15) & (16) specifically refer to a federal policy to encourage community mental health treatment centers and to promote mental health care.

The act establishing the National Institute of Mental Health (NIMH), P.L. 93-282, 88 Stat. 135 (1974), 42 U.S.C. § 289 k-1, later transferred in 1983 to 42 U.S.C. § 290aa, acknowledges that the mental health field deserves nationwide attention and research to address serious problems in mental health care. Sections 289 k-1(d) and 290aa (3) refer directly to state activity in addressing mental health care problems.

clear policy of Congress. Under the NLRA's preemption standards which recognize states' police powers, *Allen-Bradley Local* v. *Wisconsin Employment Relations Bd.*, 315 U.S. at 749, § 47B should not be overriden.

b. The State's Police Power to Regulate Employment Conditions.

Although, § 47B may involve, in some tangential manner, employee-employer relations, that alone is not inconsistent with the states' police power to regulate employment conditions. In conjunction with the obligation of the states to promote the general and mental health of their citizens, states also have the authority under their police powers to regulate for the protection of their workers' health, notwithstanding an effect on the employment relationship. *De Canas* v. *Bica*, 424 U.S. 351, 356 (1976). The *De Canas* Court cited state child labor laws, minimum and other wage laws, occupational health and safety laws and workmen's compensation laws as examples of traditionally permissible state laws enacted pursuant to the states' police power. *Id.*; *West Coast Hotel Co.* v. *Parrish*, 300 U.S. 379, 393 (1937) ("In dealing with the relation of employer and employee, the [state] Legislature has a wide field of discretion in order that there may be suitable protection of health and safety, and that peace and good order may be promoted through regulations designed to insure wholesome conditions of work and freedom from oppression."); *See also Mountain Timber Co.* v. *Washington*, 243 U.S. 219, 243 (1917) ("a State, in the exercise of its power to pass such legislation [workmen's compensation laws] as reasonably deemed to be necessary to promote the health, safety and general welfare of its people . . . may require that these human losses shall be charged against the industry . . ."). Further, except for conflicts with federal law, there are no limitations on the types of laws which states may enact under their police power that affect the business-labor field; in fact, states are encouraged to function as "laboratories" and to legislate new solutions to problems experienced in that area. They have

> the constitutional authority to experiment with new techniques, are entitled to their own standard of public welfare, and may within extremely broad limits control practices in the business-labor field, so long as specific constitutional prohibitions are not violated and so long as conflicts with valid and controlling federal laws are avoided.

Day-Brite Lighting, Inc. v. *Missouri*, 342 U.S. 421, 423 (1952), *reh. den.*, 343 U.S. 921 (state statute requiring employer to pay employee for time spent voting is constitutional).

In adopting § 47B, it cannot be overlooked that the Commonwealth sought to protect the state's working class people; the recognition by the legislature that adequate mental health care was not being given to members of the working population of the state because such treatment was not affordable was one of the principal bases for enacting § 47B (A. 430). The legislature recognized that less serious mental health problems experienced by workers were not being treated, which in turn led to their experiencing physical and medical problems requiring medical treatment and in some cases hospitalization, all of which was potentially avoidable had treatment been available at earlier stages of illness (A. 436). Testimony at trial indicated that mental health problems experienced by working class persons do affect their work productivity (A. 218). It is commonly accepted in the mental health profession that symptoms in working people of decreased work productivity, increased absenteeism, increased industrial accidents, increased filing of grievance complaints, and increased employee turnover very often are examples of symptoms of mental illness (A. 218).[33]

Thus, § 47B is fully consistent with the states' police power to protect the worker within the employment relationship. *De Canas* v. *Bica*, 424 U.S. 351.

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[33] See n.4, *supra*. *See also* Harwood, *Economic Costs to Society of Alcohol and Drug Abuse and Mental Illness*, 1980 (Report submitted to Alcohol, Drug Abuse & Mental Health Administration, Contract #ADM 283-83-002 at 34).

By suggesting that § 47B is preempted by the NLRA, the appellants seek to undercut protections which the state affords workers. If § 47B cannot apply to insurance policies purchased in conformance with collective bargaining agreements, workers who benefit from the NLRA-protected bargaining process may receive fewer mental health benefits than non-union coworkers. Moreover, because non-union workers are often covered by benefit plans agreed to in the context of collective bargaining, the appellants' argument would mean that such non-union workers would not be able to realize the benefits afforded by § 47B. Federal labor law policy cannot be stretched to achieve such absurd results.

2. The States' Right to Legislate in the Area of Insurance; the McCarran-Ferguson Act.

Apart from the states' police power authority to regulate in matters of mental health and employment, Congress has explicitly given the states primacy in the area of insurance regulation. Such congressional deference, codified in the provisions of the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015, is firm evidence of congressional intent for the states to regulate insurance free from preemption by the NLRA. *See Malone* v. *White Motor Corp.*, 435 U.S. 497; *New York Tel. Co.* v. *New York State Dept. of Labor*, 440 U.S. 519.

Like Metropolitan, Travelers also maintains, however, that § 47B does not regulate the business of insurance within the meaning of the McCarran-Ferguson Act and is therefore preempted. (*See* discussion at 29-32, *supra*.) But there is no doubt that § 47B was enacted for the purpose of regulating the business of insurance. It completely satisfies the definition of the "business of insurance" delineated in the *National Securities, Royal Drug* and *Pireno* cases.[34]

The whole thrust of § 47B is to regulate the types of accident and sickness insurance policies that may be sold in the

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[34] *SEC* v. *National Secur., Inc.*, 393 U.S. 453 (1969); *Group Life & Health Ins. Co.* v. *Royal Drug Co., Inc.*, 440 U.S. 205 (1979); *Union Labor Life Ins. Co.* v. *Pireno*, 458 U.S. 119 (1982).

state by requiring policies issued here to contain minimum benefits coverage.[35]

The legislature perceived that to combat the problems in the area of mental health treatment, it was necessary to adjust the mental health insurance market, spread the risk of insuring "bad risks" to all insurance companies offering accident and sickness insurance coverage, and create relationships between insurance companies and policyholders, where, because of the unaffordability of such policies, there had been none before.

But the appellants argue further that, even if § 47B is a law regulating the business of insurance, § 1014 of the McCarran Act exempts the NLRA from § 1012(b) of the Act because under § 1014, the NLRA is a law which "specifically relates to the business of insurance" as that phrase is used in § 1012(b). This novel argument is plainly erroneous because Congress did not intend that the NLRA be construed as a law which "specifically relates to the business of insurance," and the language of § 1014 does not support appellants' contention.

As always, the analysis must begin with the plain language of the statute. Section 1012(b) of the McCarran-Ferguson Act reads in its entirety:

> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, *unless such Act specifically relates to the business of insurance*: Provided, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall

[35] There is no expression in the McCarran Act that a state statute may have only one purpose. Section 47B has the purpose of combatting inadequate mental health care *through* the mechanism of correcting the voluntary mental health insurance market.

> be applicable to the business of insurance to the extent that such business is not regulated by State Law.

15 U.S.C. § 1012(b) (emphasis supplied).

Section 1014 reads in its entirety:

> Nothing contained in this chapter shall be construed to affect in any manner the application to the business of insurance of the Act of July 5, 1935, as amended, known as the National Labor Relations Act, or the Act of June 25, 1938, as amended, known as the Fair Labor Standards Act of 1938, or the Act of June 5, 1920, known as the Merchant Marine Act, 1920.

15 U.S.C. § 1014.

Read together these two sections of the McCarran Act constitute an harmonious whole. State laws regulating the business of insurance, like § 47B, are preempted only when Congress specifically so provides in the federal act. 15 U.S.C. § 1012(b). Moreover, even the laws which Congress has indicated do specifically relate to the business of insurance, such as the Sherman, Clayton and FTC Acts, displace state law only to the extent that the business of insurance is not already regulated by state law. *Id.*

Had Congress intended the result advanced by the appellants, § 1014 could easily have stated that the NLRA, the Fair Labor Standards Act (FLSA), or the Merchant Marine Act (MMA) are acts which "specifically relate to the business of insurance," as that phrase is used in § 1012(b), or Congress could have included them in its list of excepted federal acts in that section. But Congress treated the two sections of the Act differently, establishing that the obvious purpose of § 1014 is to ensure the application of the NLRA, FLSA and MMA to employers engaged in the business of insurance. It is evident that neither the NLRA, FLSA nor MMA are acts which "specifically relate

to the business of insurance," rather, they are laws which regulate labor relations.[36]

The McCarran-Ferguson Act was designed to "assure that the activities of insurance companies in dealing with their policyholders would remain subject to state regulation," *SEC* v. *National Secur., Inc.*, 393 U.S. at 459, absent congressional action "specifically relat[ing] to the business of insurance". 15 U.S.C. § 1012(b). The pre-existing NLRA was not and has not been deemed to be such federal insurance legislation.

Congress intended by Section 1012(b) that no federal law which related to interstate commerce could be found also to regulate the business of insurance, unless that law *specifically* related to the same. Senator Ferguson, the Act's co-sponsor said:

> If there is on the books of the United States a legislative act which relates to interstate commerce, if the act does not specifically relate to insurance, it would not apply at the present time. Having passed the bill now before the Senate, if Congress should tomorrow pass a law relating to interstate commerce, and should not specifically apply the law to the business of insurance, it would not be an implied repeal of this bill, and this bill would not be affected, because the Congress had not, under subdivision (b), said that the new law specifically applied to insurance. 91 Cong. Rec. 481 (1945).

In harmony with Senator Ferguson's comments, the McCarran-Ferguson Act includes those federal laws which might permis-

[36] While the case law is sparse, it is precisely because the application of the two sections of the statute is so clear. In this case below, for example, the Massachusetts Supreme Judicial Court held, without extended discussion, that the labor relations and employment conditions within insurance companies should not be exempt from the applicability of collective bargaining and minimum wage and hour laws. *Atty. Gen.* v. *Travelers Ins. Co.* (J.S. App. 30a-31a, n.25); *See also John Hancock Mut. Life Ins. Co.* v. *Commissioner of Ins.*, 349 Mass. 390, 398, 308 N.E.2d 516 (1965). The appellants have cited no case which supports their position that because of § 1014, the NLRA overrides state insurance laws (Travelers Brief at 38-45).

sibly have some application to the business of insurance. *See* 91 Cong. Rec. 483 (1945) (statement of Sen. Mahoney). In light of this history, if Congress truly had wanted the full panoply of labor relations statutes to "specifically relate to the business of insurance," and to preclude application of state law, it would have so specified two years later in passing the Labor Management Relations Act (LMRA), 29 U.S.C. §§ 141-187, which contains the NLRA, 29 U.S.C. §§ 151-168, but it did not.

The weakness of appellants' argument is demonstrated by carrying the argument to its logical extreme. If appellants' arguments that the NLRA displaces state regulation of insurance were adopted, then *any* instance in which the collective bargaining process were in some way affected by state insurance regulation would permit avoidance of otherwise permissible state regulation. A collective bargaining agreement which might provide for any type of insurance, including life, health, disability, or automobile, need not respect state laws.

In neither the NLRA nor the McCarran-Ferguson Act did Congress seek to foreclose legitimate state regulation of insurance policies as applied to employment benefit packages. Such matters are well within the sphere of protected state activity for the promotion of public health.

Conclusion.

For the reasons set forth above, the decisions of the Supreme Judicial Court should be affirmed.

Respectfully submitted,

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No. 84-325 and 84-356

IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

METROPOLITAN LIFE INSURANCE COMPANY,
Appellant,

v.

COMMONWEALTH OF MASSACHUSETTS,
Appellee.

THE TRAVELERS INSURANCE COMPANY,
Appellant,

v.

COMMONWEALTH OF MASSACHUSETTS,
Appellee.

On Appeal from the Supreme Judicial Court for the Commonwealth of Massachusetts

---

BRIEF OF THE NATIONAL CONFERENCE OF STATE LEGISLATURES, THE COUNCIL OF STATE GOVERNMENTS, THE NATIONAL LEAGUE OF CITIES, THE NATIONAL ASSOCIATION OF COUNTIES, THE U.S. CONFERENCE OF MAYORS, AND THE INTERNATIONAL CITY MANAGEMENT ASSOCIATION AS *AMICI CURIAE* IN SUPPORT OF APPELLEE

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QUESTION PRESENTED

Whether the Employment Retirement Income Security Act (ERISA) preempts state laws requiring health insurance policies to provide particular minimum benefits to the insured.

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BRIEF OF THE NATIONAL CONFERENCE OF STATE LEGISLATURES, THE COUNCIL OF STATE GOVERNMENTS, THE NATIONAL LEAGUE OF CITIES, THE NATIONAL ASSOCIATION OF COUNTIES, THE U.S. CONFERENCE OF MAYORS, AND THE INTERNATIONAL CITY MANAGEMENT ASSOCIATION AS *AMICI CURIAE* IN SUPPORT OF APPELLEE

INTEREST OF AMICI CURIAE

The *amici* are organizations whose members include state, county and municipal governments and officials located throughout the United States. *Amici* and their members have a vital interest in legal issues that affect

the powers and responsibilities of state and local government.

The question in this case—whether the Employee Retirement Income Security Act (ERISA) preempts all state laws requiring health insurance policies to provide minimum mental health benefits to the insureds—is one of vital importance to *amici* and their members.

States are deeply concerned that citizens suffering from crucial medical problems be covered by insurance and receive treatment. Many people first discover in the middle of a medical crisis that their health insurance policy does not protect them from the ravaging cost of medical care. To close unacceptable gaps in private health insurance coverage, 49 states now mandate various forms of minimum coverage in all health insurance policies sold in the state.[1] Mandated benefits include neo-natal care, dependent care, coverage for catastrophic illness and coverage for alcohol and drug problems.[2] In addition, Massachusetts and at least 27 other states mandate insurance coverage for mental illness.

States have an additional interest in providing for expanded insurance coverage of serious health problems through insurance. Advances in medical science have created a need for more private and public health programs. The demand for high quality health care is enormous and growing, but states have a limited fiscal capacity to meet even the present call for services. Nor is the federal government meeting the need for servics. The state policy at issue here accommodates this need by promoting a better level of health care for citizens and earlier treatment for mental illness and other medical problems. Moreover, the state policy accomplishes this without additional overwhelming economic burdens being placed on state and local governments, which already spend approximately $40 billion a year on health and medical care.[3]

[1] Blue Cross Association: G. Scandler, Total Number of States With Mandated Coverage (1984) (unpublished report available at Blue Cross Association, Washington, D.C.).

[2] Blue Cross Association: Legal Affairs Bulletin and G. Scandler, Total Number of States With Mandated Coverage (1984) (unpublished report available at Blue Cross Association, Washington, D.C.).

The foregoing shows that the legal issues presented by this case are of great importance to state governments, especially since a decision adverse to Massachusetts would eviscerate the mandated benefit laws of no less than 49 states. Thus *amici* are submitting this brief to assist the Court in its resolution of this action.[4]

STATEMENT OF THE CASE

Amici agree with the statement of facts submitted by the Commonwealth of Massachusetts. In addition, *amici* wish to call the Court's attention to the following facts, which demonstrate the importance of this case to state and local government:

A. Health Insurance, Which Is an Essential Means of Covering Health Costs, Often Has Gaps In Coverage And Appears To Be Preeminently Obtained By Means Other Than Collective Bargaining Agreements.

1. Health care cost $286.6 billion nationally in 1981. This was an estimated 9.8 percent of the gross national product.[5] Because the cost also averaged $1,225 per person, it is plain that few families could afford the entire

[3] Total state and local government expenditures for health and medical care in 1981 were $38.6 billion. Health Insurance Ass'n. of America, *Source Book of Health Insurance Data*, 1982-83, Table 4.1. The public health programs of State health agencies cost $4.9 billion a year. This does not include funds expended for public health purposes by other state agencies. Nor does it include expenditures of local health departments. Health Insurance Ass'n. of America, *Source Book of Health Insurance Data*, 1982-83, Table 4.7.

[4] Pursuant to Rule 36, the parties have consented to the filing of this *amicus* brief. Their letters of consent have been lodged with the Clerk of the Court.

[5] Health Insurance Ass'n. of America, *Source Book of Health Insurance Data, 1982-83*, Table 5.1 and Table 5.2.

costs of health care unaided.[6] An essential way of covering these costs is through health insurance.

By the end of 1981, more than 188 million Americans, or 84 percent of the civilian non-institutional population, were protected by some form of private health insurance.[7] With the growth of private health insurance plans, however, states have become increasingly concerned about the quality and the extent of coverage that these plans provide to insured individuals.

It has been found that private plans too often have serious gaps in coverage, gaps which exist until states mandate the necessary coverage. For example, neo-natal care or newborn coverage was not provided in most health insurance policies until mandated by law. Newborn babies usually were not covered by insurance until 10 to 30 days after birth. Parents of newborn children with congenital medical problems often found themselves uninsured and faced with devastating medical bills.

Gaps in coverage have also been found in other important medical areas, including maternity care, catastrophic illness, mental health, and alcohol and drug problems. A major reason for the gaps in coverage is the problem of adverse selection of risks. This problem exists when particular forms of coverage are optional. To illustrate, persons of an age where they do not expect catastrophic illness may not purchase optional insurance providing for coverage of such illness. This limits the pool of applicants for the insurance and drives up the price to prohibitive levels. A state law which mandates coverage for catastrophic illness spreads the risks and costs over a wider pool of insureds, and thereby causes the insurance to be available at a reasonable price.

2. Private health insurance plans are predominantly group plans, and it seems highly likely that vast numbers

[6] *Source Book of Health Insurance Data, supra,* Table 5.3.

[7] *Source Book of Health Insurance Data, supra,* at 7 and Table 1.1.

of individuals covered by health insurance—probably even the overwhelming majority of such persons—have not received their coverage as a result of collective bargaining agreements. This is indicated by statistics. As said above, by the end of 1981 over 188 million Americans had some form of private health insurance. Although over 137 million of these people were members of group plans by 1980,[8] in 1978, the most recent year for which statistics are available, labor union membership nationally was only 21,784,000.[9] Furthermore, by 1979, when 43.6 million full-time private sector employees were covered by group health plans, only 14.01 million of them were union members with a right of collective bargaining. Similarly, though by 1979 11.4 million full-time government workers were covered by group health plans, in 1980 only 4.9 million full-time government employees were union members with a right of collective bargaining.[10] Thus though definitive statistics are not available, it seems obvious that most covered individuals obtain insurance not because of collective bargaining agreements, but because of voluntary provision by an employer or by means of self purchase.

B. Massachusetts Adopted Section 47B Only After Careful Consideration of the Problems of Inadequate Coverage.

In 1973, Massachusetts enacted a law requiring any general health insurance policy to provide minimum bene-

[8] In 1981, 855,000 group plans were on file nationally. U.S. Dept. of Labor, *Report of Labor Management Services Administration* 32 (1982 report).

[9] U.S. Dept. of Comm., *Statistical Abstract of the United States, 1984,* 104th ed. No. 155, Persons With Health Care Coverage by Type of Coverage; Number 729, Employed Workers in Labor Organizations; No. 728, Labor Organization Membership; No. 726, Labor Union and Employee Association Membership.

[10] U.S. Dept. of Labor, *Group Health Insurance Coverage of Private Full-Time Wage and Salary Workers, 1979* (1981).

fits for beneficiaries suffering from mental health conditions (Massachusetts Gen. Laws ch. 175, § 47B).[11] This law was adopted only after extensive legislative consideration and hearings, and a lengthy report of the Legislature's Joint Committee On Insurance.[12] It was enacted to meet the serious health problem caused by inadequate and delayed treatment of mental illness.

Massachusetts was acting "on some grave problem areas since years were passing without any policy emerging from Washington."[13] The legislature was especially concerned with the spread of mental illness among workers and among the poor. However, because mental illness strikes indiscriminately, the coverage "safeguards the . . . young and old, rich and poor, against the burden-

[11] The law requires that minimum mental health care benefits for inpatient care must be provided in all general health insurance policies. And, to the extent of $500 over a 12-month period, outpatient care must also be covered, if provided by comprehensive mental health organizations, licensed or accredited hospitals or community mental health centers. See Appendix, *infra*.

[12] The Report of the Joint Committee on Insurance was carefully considered by the courts below in reaching their decision. For example, the Supreme Judicial Court of Massachusetts in its March 24, 1982 opinion stated in footnote 24:

> "A report of the Joint Committee on Insurance of the General Court, incorporated into the findings of the judge below, demonstrates that the Legislature was concerned with the spread of mental illness among workers and among the poor. In the committee's view, mental health insurance programs would encourage community-based, out-patient care and decrease the need for institutionalization. 'Mental illness strikes indiscriminately among young and old, rich and poor. A need therefore exists for all people to be safeguarded against the high and sometimes crippling costs of professional mental health care today.' General Court Joint Committee on Insurance, Advances in Health Insurance in Massachusetts 9 (1974)."

[13] Report on the legislation, the Joint Committee on Insurance of the Massachusetts General Court. Joint Appendix of the Parties (hereafter J.A.)-427.

some cost of professional mental health services and care."[14] The legislature found that inpatient institutional care in mental hospitals was often obsolete and in many cases very damaging.[15] But "[o]utpatient care given at a local community mental health center . . . enables the mentally ill to receive adequate treatment without costly institutionalization . . ."[16]

The Committee noted that because only one percent of the people of the Commonwealth were previously insured for outpatient care, community mental health centers had been publicly supported, costing Massachusetts taxpayers millions of dollars annually. However, "[b]y making mental health care coverage mandatory, Massachusetts can continue the thrust toward community-based care . . . increas[ing] the availability for treatment in privately run mental health centers but sav[ing] the taxpayers money as well."[17]

Mental health insurance, the Committee found, can be offered at a reasonable cost only when included in large group policies. Also, for the cost to be reasonable, insurance for mental illness has to be a mandatory feature of all policies sold in the state. "An optional offer to cover mental illness is contrary to the most basic principle of insurance—that of 'risk sharing'."[18]

The committee also found that insurance coverage for mental health was not abused where it was offered and

[14] Report on the legislation, *supra*, J.A.-430-431.

[15] Report on the legislation, *supra*, J.A.-431.

[16] Report on the legislation, *supra*, J.A.-432. Deinstitutionalization of the mentally ill and mentally retarded is a policy that has received considerable support and encouragement from the federal government. *See, e.g., Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1 (1981).

[17] Report on the legislation, *supra*, J.A.-432.

[18] Report on the legislation, *supra*, J.A.-433.

that it decreased non-psychiatric medical care for so-called physical ailments. A study by the Group Health Association in Washington, DC, for example, demonstrated that providing mental health services substantially reduced the amount of nonpsychiatric care that was needed.[19] The patients who received outpatient psychiatric treatment required a significantly smaller amount of services from physicians and fewer laboratory and X-ray procedures.

The Committee concluded that to enlarge the community health care system "and make [outpatient treatment] available to millions of Massachusetts residents mental health insurance must be mandatory . . ." [20]

SUMMARY OF ARGUMENT

I.

Forty-nine states have enacted laws which require health insurance companies to include various types of medical benefits in their insurance policies. The states passed these laws to protect their citizens against medical problems which are a menace to public health. If the laws are held preempted, millions of citizens will be left unprotected against these problems.

However, when it enacted ERISA, Congress did not intend to preempt the state laws. This is not only the position of *amici*, but is the position that has been expressed to the Court by the federal government, whose law is involved.

Such position is supported by ERISA's broad savings clause, under which state laws regulating insurance are exempted from preemption. Moreover, when it enacted ERISA, Congress was aware of state insurance laws requiring carriers to provide various benefits, yet it nevertheless inserted the broad savings clause exempting state insurance laws from preemption. In so doing, Congress adhered to its traditional position that regulation of insurance is for the states.

[19] Report on the legislation, *supra*, J.A.-435.

[20] Report on the legislation, *supra*, J.A.-437.

Furthermore, Congress did not deal in any way with the substantive content of health insurance policies when it enacted ERISA. Thus, if state mandated benefit laws such as Section 47B are struck down, citizens will have *no* government protection, be it federal *or* state. Nor will vast numbers of citizens obtain whatever protection can be secured through collective bargaining. For millions of citizens—very likely the vast majority of those who are covered by health insurance—do not obtain their coverage by means of collective bargaining agreements.

Finally, appellants argue that in the absence of preemption there will be a lack of uniformity among state mandated benefit laws. Their argument is addressed to the wrong forum. It should be addressed to Congress, which contemplated non-uniformity when it inserted the savings clause exempting state insurance laws from preemption.

II.

State mandated benefit laws are not preempted by the NLRA. Congress did not intend the NLRA to supersede state laws regulating insurance. And it is inconceivable that Congress intended the NLRA to strip states of their historic power to safeguard the public health—a result which would ensue if there is preemption here.

Moreover, there also is no preemption under the tests the Court often uses in labor matters. First, laws such as Section 47B are deeply rooted in local feeling and responsibility because they protect the local public health. Second, they do not affect any economic weapon (such as strikes) used by labor or management.

ARGUMENT

I. STATE LAWS MANDATING MINIMUM HEALTH INSURANCE BENEFITS ARE NOT PREEMPTED BY ERISA

A. Introduction

This case presents a fundamental question of preemption which deeply concerns state and local governments. The principal issue is whether ERISA prohibits states from protecting the health of their citizens by requiring that health insurance policies provide minimum benefits for such serious problems as mental illness, catastrophic illness, medical care for newborn babies, and dependency on alcohol or drugs. Massachusetts and 48 other states have enacted laws that mandate minimum benefits because these problems are a menace to public health, there have been gaps in insurance coverage, and the laws reduce the costs of insurance because of a wider sharing of risk.

Moreover, as this Court has recognized, Congress, when it enacted ERISA, did not deal in any way with the substantive content of health insurance plans. *Shaw v. Delta Air Lines, Inc.*, 103 S.Ct. 2980, 2897 (1983). Instead, Congress left the regulation of insurance to the states, which have traditionally exercised such power of regulation. There is thus no conflict between ERISA and Section 47B of the Massachusetts law. To the contrary, if Section 47B were held preempted, tens of millions of citizens would be left without any protective regulation, federal *or* state. Thus, in enacting mandated benefit laws, states are acting in pursuit of the legitimate and traditional state purpose of protecting the health and welfare of their citizens. In this regard, statutes such as Section 47B exemplify state innovation designed to solve significant social problems without reliance on Washington for help.

B. Congress Saved State Insurance Laws From Preemption by ERISA

1. As this Court recently stated, "Preemption of state law by federal statute or regulation is not favored 'in the absence of persuasive reasons—either that the nature of the regulated subject matter permits no other conclusion, or that the Congress has unmistakably so ordained.'" *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 522 (1981). "Persuasive reasons" for preemption exist when there is an actual conflict between state and federal law, i.e. when "compliance with both federal and state regulations is a physical impossibility," *Florida Lime and Avocado Growers Inc. v. Paul*, 373 U.S. 132, 142-143 (1963), or when state law "stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." *Hines v. Davidowitz*, 312 U.S. 52, 67 (1941).

There are no such "persuasive reasons" for preemption in this case. Though Section 514 of ERISA provides that all state laws that "relate" to employee benefit plans are preempted,[21] this clause is followed by a broad savings clause which exempts state insurance laws from preemption: "Except as provided in subparagraph (B), nothing in the subchapter should be construed to exempt or relieve any person from any law of any state which regulates insurance. . . ." [22] Thus, instead of *preempting* state laws regulating insurance, Congress has expressly said that they are *free* of preemption.[23]

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[21] ERISA Section 514(a), 29 U.S.C. § 1144(a). See Appendix, *infra*.

[22] ERISA Section 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). See Appendix, *infra*.

[23] Section 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B) provides that no state can deem an employee benefit plan to be an insurance company, or to be engaged in the business of insurance, for purposes of "regulating" insurance. This "deemer" clause simply prohibits

The federal government, whose law is involved here, has agreed that state laws which require insurance policies to provide mental health benefits are not preempted by ERISA. It has said these laws are excluded from preemption by the savings clause even though they indirectly affect employee benefit plans which purchase the insurance policies.[24] As the Solicitor General said:

> "This savings provision would be meaningless unless it saved from preemption state laws regulating insurance which also indirectly regulate employee benefit plans, since no other state law regulating insurance would be subject to preemption under the Act even in the absence of the savings provision. Chapter 57 obviously "regulates insurance," and thus the court correctly found that Congress intended that law and others like it to remain effective regardless of ERISA's otherwise broad preemption of state laws relating to plans. . . .[25]
>
> The fact that the purchaser of insurance is an employee benefit plan is immaterial; Congress did not intend to confer any special exemption or privilege on them as insurance buyers. Insurance sales to them must conform to the same rules as those to any

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the state from regulating employee welfare benefit plans by calling them insurers. It does not prohibit the state from regulating bona fide insurers when they are doing business with employee benefit plans. Note, *ERISA Preemption and Indirect Regulation of Employee Welfare Plans Through State Insurance Laws*, 78 *Col. L. Rev.* 1536, 1541 (1978).

[24] Memorandum for the United States as *amicus curiae*, filed March 27, 1978, at the request of the Court, *Wadsworth v. Whaland* and *Dawson v. Whaland*, Nos. 77-765 and 77-772, October Term 1977. *Wadsworth v. Whaland*, 561 F.2d 70 (1st Cir. 1977), *cert. denied*, 435 U.S. 98 (1978).

[25] The issue in *Wadsworth v. Whaland* was whether a New Hampshire statute, Chapter 57 of N.H. Rev. Stat. Ann. of Laws of 1976, which mandates mental health benefits in group health insurance policies, was preempted by ERISA.

> other insurance buyer, and if a state determines, as New Hampshire has done here, that all group health insurance sold in the state must provide coverage for mental and emotional disturbance, the plans may purchase no other. . . .
>
> "Congress preserved authority in the states to regulate insurance, and if petitioners find the result burdensome their recourse is to Congress, or to the state legislatures, rather than to this Court." [26]

The position of *amici*, and that expressed by the Solicitor General, is supported by the legislative history surrounding the passage of ERISA. In 1974, the year ERISA was enacted, at least 16 states had insurance laws that mandated particular health benefits in insurance policies.[27] Congress was aware of the functions and scope of such laws, yet specifically exempted state laws regulating insurance from the preemption clause of ERISA.[28] Moreover, Congress did not seek to deal in any way with the substantive content of insurance—which is what laws like Section 47B *do* deal with.[29] Rather, as this Court has recognized, Congress intended only to establish reporting, disclosure and fiduciary requirements for pension and welfare benefit plans.[30]

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[26] Memorandum for the United States, *supra* at 7-9. (Footnote added.)

[27] Blue Cross Association: G. Scandler, Total Number of States With Mandated Coverage (1984) (unpublished report). The earliest mandated benefit plans were adopted in the late 1960s. By 1974, 16 states had enacted newborn coverage, 4 states had enacted mental health coverage and 5 states had alcohol abuse coverage.

[28] *Wadsworth v. Whaland*, 562 F.2d 70 (1st Cir. 1977), *cert. denied*, 435 U.S. 98 (1978). *Insurance Commissioner v. Metropolitan Life Ins. Co.*, 296 Md. 334, 463 A.2d 793 (1983).

[29] *Shaw v. Delta Air Lines, Inc.*, 103 S.Ct. 2890, 2896 (1983).

[30] Appellants argue that laws such as 47B are preempted because this Court has said ERISA's preemption provision is very broad and even covers subjects not dealt with in ERISA. Brief for Appellant

2. Congressional intent to leave states free to regulate the content of insurance policies is further indicated by the fact Congress has traditionally supported—and when necessary re-established—state regulation of insurance. From the 1869 decision in *Paul v. Virginia*, 8 Wall. 168 (1869), to the 1944 decision in *United States v. South-Eastern Underwriters Ass'n.*, 322 U.S. 533 (1944), insurance was considered not to be interstate commerce and was therefore regulated by the states. When the Court ruled in *South-Eastern Underwriters*[31] that insurance *is* interstate commerce, a ruling which made insurance susceptible to federal regulation instead of state regulation, Congress quickly passed the McCarran-Ferguson Act[32] to give support to existing and future state systems for regulating and taxing insurance. *Prudential Insurance Co. v. Benjamin*, 328 U.S. 408, 429 (1946).

The Act specifically allows states to regulate the "business of insurance." The business of insurance is precisely what is regulated by state laws requiring health insurers to provide specified benefits to their insureds. This is only common sense. It is also supported by precedent. For the Court has said "[T]he core of the 'business of insurance'" encompasses "[t]he relationship between insurer and insured, the type of policy which could be issued. . .", *Securities and Exchange Comm'n v. National Securities, Inc.*, 393 U.S. 453, 459-460, and that the business of insurance includes "the contract between the insurer and the insured." *Group Life & Health Insur-*

Metropolitan Life Insurance Company at p. 13. But the savings clause broadly excepts insurance from the preemption provision, and the Court's statements which indicate the breadth of the preemption provision were not intended to indicate a narrow scope for the savings clause. To the contrary, the Court specifically said that ERISA's concerns are *limited* by the savings clause. *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523, f.n. 19 (1981).

[31] *United States v. South-Eastern Underwriters Ass'n, supra*, 322 U.S. 533 (1944).

[32] 15 U.S.C. Section 1011 *et seq.* See Appendix, *infra*.

ance Co. v. Royal Drug Co., 440 U.S. 205, 215 (1979). These matters were summarized in *Securities and Exchange Comm'n v. National Securities, Inc.*, 393 U.S. 453:

> "Congress was concerned with the type of state regulation that centers around the contract of insurance. . . . The relationship between insurer and insured, the type of policy which could be issued, its reliability, its interpretation, and enforcement—these were the core of the 'business of insurance'. Undoubtedly, other activities of insurance companies relate so closely to their status as reliable insurers that they must be placed in the same class. But whatever the exact scope of the statutory term, it is clear where the focus was—it was on the relationship between the insurance company and the policy holder. Statutes aimed at protecting or regulating this relationship, directly or indirectly are laws regulating the business of insurance." *Securities & Exchange Comm'n. v. National Securities, supra* at 460.[33]

3. If the Court were to find preemption here, millions of citizens would be left without necessary protections. As pointed out above, in the absence of state laws requiring particular benefits, there are gaps in health insurance coverage and certain forms of health insurance are prohibitively expensive. Crucial coverage such as neo-natal care, care of mental health problems, and catastrophic illness insurance are either unobtainable or unobtainable at affordable prices. Furthermore, Congress did not deal with this problem in ERISA, as ERISA does not touch the substantive content of health insurance policies. Thus citizens will be deeply and adversely affected if laws such as Section 47B are struck down.

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[33] Appellants claim that, because it is intended to protect public health, Section 47B does not regulate insurance. The claim is plain error. Section 47B protects the public health *by* regulating insurance.

Moreover, vast numbers of citizens—probably even the overwhelming majority of those who possess some form of health insurance—will not secure whatever protections can be obtained through collective bargaining. Although defendants lay much stress on their claim that laws such as Section 47B allegedly interfere with the results of collective bargaining, the available data indicates that huge numbers of citizens obtain health insurance by means other than such bargaining. They obtain it either by unilateral action of an employer or by self-purchase. That collective bargaining is irrelevant to most people in connection with health insurance is shown by the statistics. In 1979, 14 million full-time union members with a right of collective bargaining were covered by health insurance policies, but shortly thereafter the total number of individuals with health insurance was almost 14 times greater than this: it was 188 million. As well, 43 million full-time private sector employees were covered by group health plans in 1979, but only 14 million of them were union members with a right of collective bargaining. And 11 million full-time government workers were covered by group health plans by 1979, though in 1980 only 5 million full-time government employees were union members with a right of collective bargaining.[34]

The fact that a finding of preemption will leave huge numbers of people without crucial types of medical benefits counsels strongly against such a ruling, for it would be very odd if a law enacted to protect workers—ERISA—were to result in their being deprived of crucial protections. It would be equally odd if ERISA were held to knock out the protective laws of 49 states dealing with a subject that Congress did not even touch when it enacted ERISA.

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[34] The foregoing statistics are contained in or derived from the authorities cited in notes 3, 5, 9 & 10, *supra*.

We also note that, as mentioned earlier, by 1981 there were 855,000 employee welfare benefit plans. The persons insured under vast number of those plans would be left without protection.

4. Appellants claim there must be preemption because otherwise there will be lack of unformity in state laws that mandate particular forms of health insurance coverage. Their argument is addressed to the wrong forum. Congress specifically allowed nonuniformity when it expressly provided that laws regulating the business of insurance are saved from preemption. Congress knew insurance laws vary from state to state, but it saved them from preemption in deference to the long tradition of state regulation of insurance, a tradition which recognizes that in a federal system not all laws will be the same and not all laws should be made in Washington. If defendants object to the nonuniformity expressly contemplated by Congress, they should address their arguments to Congress instead of seeking judicial amendment of the statute.[35]

II. SECTION 47B IS NOT PREEMPTED BY THE NATIONAL LABOR RELATIONS ACT

Appellants assert that Section 47B is preempted by the National Labor Relations Act (NLRA).[36] The assertion is incorrect. There are no "persuasive reasons" for such

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[35] The only matter at issue here is whether ERISA preempts a state law requiring insurance companies to provide particular benefits in health insurance policies which they sell to others. A question *not* at issue is whether a state could require an employer to provide particular forms of health benefits to his own employees. Massachusetts appears to have conceded that, because of ERISA, a state could not require this. *Amici*, whose members include the political bodies and governing officials of many other states, do not agree with such a concession. In *Shaw v. Delta Air Lines, Inc.*, 103 S.Ct. 2890, 2905-6 (1983), the Court ruled that a state can require an employer to provide certain benefits separately from an ERISA plan, even if it cannot force him to include them in the ERISA plan itself. That logic is applicable to health benefits. Thus, if a state sought to require an employer to provide specific health benefits, it can do so even if it cannot require the benefits to be provided as part of an ERISA plan.

[36] 29 U.S.C. § 151 *et seq.*

preemption. To the contrary, there are persuasive reasons against it. *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981).

Congress enacted the NLRA to remedy "the inequality of bargaining power between employees who do not possess full freedom of association or actual liberty of contract, and employers who are organized in the corporate or other forms of ownership association. . ." 29 U.S.C. § 151. Section 47B, however, does not create any inequality of bargaining power. Moreover, at the time Congress enacted the NLRA, state regulation of insurance was long established, and Congress did not intend the NLRA to overturn this regulation. Indeed, Congress subsequently acted to assure the *continuation* of state regulation of insurance by passing the McCarran-Ferguson Act in 1945.[37] Finally, it is inconceivable that, in enacting the NLRA, Congress meant to deprive states of their historic power to protect the public health, a deprivation which would ensue if NLRA preempts state laws requiring insurers to provide important health benefits.

Nor is there preemption under the two tests this Court has often used in the labor field. Under the test laid down in *Garmon*,[38] there is no preemption if a state regulation deals with matters deeply rooted in local feeling and responsibility. Id. at 244. That is precisely the type of matter at issue here. As made clear earlier in this brief, Massachusetts, like other states, is deeply concerned that

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[37] The report of the House Committee on the Judiciary says that Congress was considering the Act "so that the several States may know that the Congress desires to protect the continued regulation and taxation of the business of insurance by the several States, and thus enables insurance companies to comply with State laws. What is more, the Congress proposes by this bill to secure adequate regulation and control of the insurance business." H. Rep. No. 143, 79th Cong., 1st Sess. (1945), reprinted in U.S. Code Cong. & Ad. News 670, 671.

[38] *San Diego Building Trades Council v. Garmon*, 359 U.S. 236 (1959).

millions of its citizens receive appropriate health insurance coverage and medical care and not be victimized by lack of coverage. It has, therefore, acted out of concern for the local public health. There is nothing more deeply rooted in local interest.

The second test, laid down in the *Machinists* case,[39] is that a state cannot regulate conduct which Congress left to the free play of economic forces. Id. at 140. The test is inapplicable here for two reasons. First, the test is correctly applied where a state seeks to affect an economic weapon (such as strikes) utilized by labor or management. *Machinists v. Wisconsin Employment Relations Commission*, 427 U.S. 132 (1976); *New York Telephone Co. v. New York State Dept. of Labor*, 440 U.S. 519 (1979). But laws like Section 47B are not intended to and do not affect any economic weapon employed by workers or management.

Second, in enacting NLRA, Congress did not intend to cause insurance or public health to be left to the "free play of economic forces" between labor and management. Rather, Congress preserved long-standing state regulation of insurance and also preserved the states' historic power to protect the public health.[40]

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[39] *Machinists v. Wisconsin Employment Relations Comm'n*, 427 U.S. 132 (1976).

[40] Like laws concerning torts or contracts, Section 47B is a neutral state law of general application. Numerous Justices have concluded that such laws are not preempted by the NLRA. *Belknap Inc. v. Hale*, 103 S. Ct. 3172, 3183 (1983) (White, J.); *Farmer v. Carpenters*, 430 U.S. 290, 296 (1977) (Powell, J.); *International Ass'n of Machinists v. Gonzales*, 356 U.S. 617, 619, 622 (1958) (Frankfurter, J.); *Linn v. United Plant Guard Workers*, 383 U.S. 53, 62 (1966) (Clark, J.); *New York Telephone Co. v. New York State Dept. of Labor*, 440 U.S. 519, 533 (1979) (Stevens, J.); *Taggart v. Weinacker's, Inc.*, 397 U.S. 223, 228 (1970) (Burger, C.J., concurring); *United Constr. Workers v. Laburnum Constr. Corp.*, 347 U.S. 656 (1954) (Burton, J.); *See* Cox, *Labor Law Preemption Revisited*, 85 Harv. L. Rev. 1337, 1355-1356, 1359-1360 (1972).

CONCLUSION

For the foregoing reasons, this Court should affirm the decision below that the Massachusetts law mandating mental health benefits in group insurance policies is not preempted.

Respectfully submitted,

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APPENDIX

McCarran-Ferguson Act

15 U.S.C. § 1012:

(a) The business of insurance and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

(b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: Provided, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

Employee Retirement Income Security Act of 1974

29 U.S.C. § 1144:

"(a) Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

"(b)(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

"(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

"(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

"(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section 1136 of this title.

"(4) Subsection (a) of this section shall not apply to any generally applicable criminal law of a State.

"(c) For purposes of this section:

"(1) The term 'State law' includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

"(2) The term 'State' includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

"(d) Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(b) of this title) or any rule or regulation issued under any such law."

Section 47B (Massachusetts Gen. Laws ch. 175 47B):

"Any blanket or general policy of insurance described in subdivision (A), (C), or (D) of section one hundred and ten which provides hospital expense and surgical expense insurance and which is issued or subsequently renewed by agreement between the insurer and the policyholder, within or without the commonwealth, during the period this provision is effective, or any policy of accident and sickness insurance as described in section one hundred and eight which provides hospital expense and surgical expense insurance and which is delivered or issued for delivery or subsequently renewed by agreement between the insurer and the policyholder in this commonwealth during the period that this provision is effective, or any employees' health and welfare fund which provides hospital expense and surgical expense benefits and which is promulgated or renewed to any person or group of persons in this commonwealth covered under any such policy or plan, arising from mental or nervous conditions as described in the standard nomenclature of the American Psychiatric Association which are at least equal to the following minimum requiremen :

"(a) In the case of benefits based upon confinement as an inpatient in a mental hospital under the direction and supervision of the department of mental health, or in a private mental hospital licensed by the department of mental health, the period of confinement for which benefits shall be payable shall be at least sixty days in any calendar year.

"(b) In the case of benefits based upon confinement as an inpatient in a licensed or accredited general hospital, such benefits shall be no different than for any other illness.

"(c) In the case of outpatient benefits, these shall cover, to the extent of five hundred dollars over a twelve-month period, services furnished (1) by a comprehensive health service organization, (2) by a licensed or accredited hospital (3) or subject to the approval of the department of mental health services furnished by a community mental health center or other mental health clinic or day care center which furnishes mental health services or (4) consultations or diagnostic or treatment sessions, provided that such services under this clause are rendered by a psychotherapist or by a psychologist licensed under the provisions of chapter one hundred and twelve. For purposes of this clause 'psychotherapist' shall mean a person fully licensed to practice medicine under the provisions of chapter one hundred and twelve, who devotes a substantial portion of his time to the practice of psychiatry." Mass. Gen. Laws ch. 175, 47B.

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No. 84-356

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In the Supreme Court of the United States

OCTOBER TERM, 1984

METROPOLITAN LIFE INSURANCE COMPANY
Appellant,
v.
COMMONWEALTH OF MASSACHUSETTS,
Appellee.
No. 84-325

THE TRAVELERS INSURANCE COMPANY,
Appellant,
v.
COMMONWEALTH OF MASSACHUSETTS,
Appellee.
No. 84-356

On Appeal from the Supreme Judicial Court for the Commonwealth of Massachusetts

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INTEREST OF AMICUS CURIAE STATE OF OREGON

This amicus curiae brief is submitted by the Attorney General of the State of Oregon on behalf of the state and its Insurance Commissioner. Pursuant to Rule 36 of the Rules of the Supreme Court, Oregon files this brief in support of appellee, the State of Massachusetts.

Oregon has a comprehensive insurance regulatory scheme governing group health insurance policies issued by insurance companies and by health care service contractors. Three of Oregon's statutes currently are under challenge in litigation pending before the Ninth Circuit Court of Appeals.[1] Plaintiffs in that litigation, like the appellants in this case, urge that states are preempted from requiring mandatory minimum benefit coverage in group health insurance policies when those policies are purchased by an ERISA welfare benefit plan. The Court's decision in this appeal will bear directly on the resolution of the Oregon case, which has been stayed pending that decision.[2]

Oregon's interest, however, is not simply that of a party involved in related litigation. Because this case involves state regulation of group health insurance, it has important

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[1] The Oregon case is *Hill v. Driscoll*, Civ. No. 84-287. The plaintiffs who brought the challenge to Oregon's statutes have filed an amicus brief in support of the appellant insurance companies.

[2] The district court granted summary judgment for defendants and issued an order rejecting the argument that ERISA preempts state regulation of group health insurance benefits. (*See* Order, App. B). On appeal, the Ninth Circuit stayed the briefing schedule until this Court decides this case. (*See* Order, App. C).

implications for the states' roles in devising effective protection against those health care risks which the various states deem to be of particular concern. Invalidation of minimum benefit insurance regulations under an ERISA preemption theory would seriously dilute if not altogether deprive Oregon of its direct regulatory control in this area of vital state concern. Consequently, the state-federal balance struck by Congress in the McCarran-Ferguson Act would be radically altered. It has been the consistent legal policy of the State of Oregon to pursue renewed recognition and validation of the principles of federalism that form the core of our nation's governmental structure under the United States Constitution. Oregon appears in order to preserve congressionally sanctioned state prerogatives in the area of insurance regulation.

SUMMARY OF ARGUMENT

The State of Oregon joins in the arguments presented by the State of Massachusetts in support of the Massachusetts Supreme Court's decision that the Employee Retirement Income Security Act of 1974 (ERISA)[3] does not preempt state laws regulating group health insurance policy benefits. Oregon appears as amicus curiae to advance two supplemental arguments which, we believe, will aid the Court's understanding of the full scope and consequences of the broad preemption theory advanced by the appellants insurance companies.

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[3] Pub. L. No. 93-406; 88 Stat. 829; 29 U.S.C. §§ 1001-1381 (1975).

1. The practical consequences of appellants' preemption arguments are potentially extreme. The enforceability of state laws governing group policy benefits lies in the uniform application of those laws. Oregon's Insurance Commissioner does not review all policies issued to ensure their compliance with state law, nor could she realistically do so. Rather, she approves general policy forms in advance and relies on her power to investigate in response to complaints or other circumstances suggesting specific violations. The broad preemption of state laws regulating group health insurance policies purchased for an ERISA plan would result in a de facto dual regulatory scheme. That scheme would be difficult if not impossible to administer and to enforce. In good faith or otherwise, purchasers might represent erroneously that a policy will insure an ERISA plan. Neither insurers, the Insurance Commissioner nor the beneficiaries of the policy realistically could scrutinize and test those representations except through litigation. Because of the difficulty of determining whether a qualified ERISA welfare plan exists, state regulations would be easily circumvented.

Ultimately, the enforcement of state laws regulating group health insurance would at best be uneven and uncertain; at worst, the states might be forced out of this aspect of insurance regulation because of the potential to mislead the public and because of the undesirability of retaining laws that cannot be effectively enforced. The state's role in insurance regulation is likely to be impaired more fundamentally than appellants' preemption argument at first suggests. That

result is directly at odds with the express provisions of both ERISA and the McCarran-Ferguson Act, and with policies that favor state primacy in the field of insurance regulation.

2. Not all state laws regulating group health insurance coverage are like the Massachusetts regulation challenged in this case. Oregon, for instance, has a significant number of statutory provisions which regulate only provider reimbursement for otherwise insured benefits. These regulations do not mandate coverage of particular benefits; rather, they ensure that state licensed professionals qualified to provide covered health services (*e.g.*, nurse practitioners) are not refused reimbursement if an insured prefers to obtain such services from such a professional rather than a physician. One of these categories of statutes has been challenged in Oregon on the same ERISA preemption theory presented here. However, arguments relating to the cost impact of state regulation on ERISA plans cannot be even colorably advanced against this type of statute. Even assuming the Court agrees with the preemption theory advanced in this case, the decision should reach only state regulation similar to that of the Massachusetts statute before the Court.

ARGUMENT

Appellants allege that section 514 of the Employee Retirement Income Security Act (ERISA) preempts application of state laws mandating minimum benefits for the beneficiaries of group health insurance policies. The issue arises when the trustees of an ERISA-qualified employee welfare benefit plan deem it inadvisable to self-insure the plan and instead seek to

gain an economic advantage from the broader risk distribution available through commercially marketed health care insurance.

As the State of Massachusetts demonstrates in its brief, the broad construction of the ERISA preemption clause urged by appellants is unsound. To so construe section 514(a) would be contrary to the express savings clause of section 514(b)(2)(A), and would render that subsection meaningless. Moreover, preemption of state mandatory benefit laws would be at direct odds with the express policy and provisions of the McCarran-Ferguson Act.[4] Finally, preemption would lead to the anomalous result that ERISA would invalidate state regulation of an aspect of ERISA plans (*i.e.*, the type and level of benefits) not regulated at all by ERISA, and not designed to be free of regulation.

The State of Oregon joins in the arguments presented by the State of Massachusetts, and will not repeat them. We appear in order to advance two discrete points only. First, we are concerned with the eventual practical consequences of the broad preemption theory presented to the Court. Realistically, if state regulations mandating minimum benefits in health insurance policies cannot be uniformly enforced, the danger is that they will not be enforced at all. Our second point is that not all state statutes regulating health insurance benefits are similar in their operation. The policy-based arguments urging that mandatory minimum

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[4] Pub. L. No. 79-15; 59 Stat. 33 (1945); 15 U.S.C. §§ 1011-1015 (1976).

benefit laws impose burdensome costs on ERISA welfare benefit plans are wholly inapplicable to many of the state laws regulating health insurance coverage and reimbursement provisions.

We make these points to demonstrate that federalism is not an abstraction in this case. The states in fact are active in the area of insurance regulation; their role is both pervasive and vital. Through a wide array of laws directed to health insurance benefits, the states have been able to address important contemporary local health issues and to improve significantly the quality of health care insurance provided to the public generally. The McCarran-Ferguson Act expressly calls on the states to play the primary role in regulating insurance. The provisions of ERISA expressly disavow that states should be divested of this role. The federal Health Maintenance Organization Act preserves for the states a complimentary regulatory function even in the federally crafted health care delivery scheme. In short, the federalism we urge the Court to preserve is real. Altering the current state-federal balance would impede seriously national efforts to improve the health of all citizens.

I. ERISA preemption of state laws regulating the contents of group health insurance policies may render such provisions unenforceable with respect to all group health policies, not only those purchased to insure ERISA employees.

The manner in which the Oregon Insurance Commissioner administers and enforces the group health policy reg-

ulatory scheme is, we believe, fairly typical of the states generally.[5] Importantly, it demonstrates that enforceability is largely a consequence of predictability and uniformity in the application of such regulations.

The Oregon Insurance Commissioner's ability to force insurance companies and other health care providers to comply with state insurance laws derives essentially from her power to authorize such insurers to do business within the state, and to revoke such authorization. In Oregon, no insurer can transact insurance except pursuant to a certificate of authority issued by the Commissioner. This requirement also exists for health care service contractors, which include federally approved health maintenance organizations (HMO's). The Commissioner has authority to investigate suspected violations of the Insurance Code and to take action for violations that ranges from entering cease and desist orders, to seeking court enforcement or restraint, and to revoking the requisite certificate of authority.[6]

The Oregon Insurance Commissioner does not ensure compliance with laws governing group health care insurance by reviewing the actual policies issued. Due to the volume of

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[5] *See* D. Brummond, *Federal Preemption of State Insurance Regulation Under ERISA*, 62 Iowa L. Rev. 59, 83 (1976), observing that most states require approval of group policy forms as a condition to marketing such policies by insurers, a system similar to that described here for Oregon.

[6] *See* Or. Rev. Stat. §§ 731.354 (issuance of certificate); 731.236(3) (investigative authority); 731.252 (cease and desist orders); 731.256 (institute actions for enforcement); 731.356 (file actions for restraint); 731.418(1)(a) (suspend or revoke certificates). The Commissioner's authority in all of these respects extend to health care service contractors. Or. Rev. Stat. § 750.005.

transactions in the insurance business, such review simply is not feasible. Instead, with few exceptions, the Insurance Commissioner approves in advance and retains on file all basic insurance policy forms which legally may be issued in Oregon. Or. Rev. Stat. § 743.006(1).[7]

The enforceability of state regulatory schemes mandating minimum benefit coverage in group health policies is thus largely dependent on the uniform application of such regulations. Insurers know precisely what every group policy must contain, and they must acquire pre-approval of many of those policies. They are unlikely to circumvent those requirements at the risk of losing their certificate to do business in the state. Members of the public may rely on the existence of state benefit laws to know with certainty their entitlement to specified coverage. The Insurance Commissioner can, also with certainty, advise individuals who inquire about state-mandated benefit protections. Further, she can provide information to the public generally about benefits mandated by state law. The regulatory system thus has a significant self-enforcing aspect: Because of its uniform scope and application, both the public and competitors within the insurance industry can better identify and report violations. In turn, the

[7] An exception exists for group health insurance policy forms agreed upon as a result of negotiations between the policyholder and the insurer. Or. Rev. Stat. § 743.006(1)(c). Ostensibly, these policies are exempted because their forms are unique and issued one time only; their filing as standard forms would serve no purpose. Whether policies purchased to insure an ERISA plan fall within the exemption depends on whether a standard group health policy is purchased or whether special policy provisions are negotiated between the insurer and the ERISA purchaser.

Commissioner can effectively investigate and establish violations, and sanction them.

A conclusion that ERISA preempts state minimum benefit laws when group health insurance is purchased for an ERISA welfare plan would result in a de facto dual regulatory scheme. State regulation would have full force in some instances and no force in others. The difficulty for insurers and the Insurance Commissioner would be to determine which purchases are for ERISA qualified plans, and which are not. There is no workable mechanism by which every group health insurance policy could be reviewed by the Insurance Commissioner to ensure that the purchaser is ERISA qualified. Even if there were such a mechanism, the determination simply could not be reliably made. Ascertaining the existence of a qualified ERISA plan is not within the scope of the Oregon Insurance Commissioner's authority, and certainly it is not within the scope of her expertise. Short of litigation, the responsibility for such a determination rests with the Secretaries of the United States Department of Labor and Department of the Treasury. *See* 29 U.S.C. § 1204. Significant controversy is generated over ERISA qualification questions, and they frequently are not susceptible of easy resolution. Often the courts must supply the answers. *See, e.g., Taggart Corp. v. Life & Health Benefits Administration, Inc.*, 617 F.2d 1208 (5th Cir.) *cert. denied*, 450 U.S. 1030 (1981) (multiple-employer insurance plan not within scope of ERISA); *Donovan v. Dillingham*, 688 F.2d

1367 (11th Cir. 1982) (some employers in multiple-employer insurance plan subject to ERISA, others possibly not).

Enforcement of a de facto dual regulatory scheme would be difficult at best. If a purchaser for a qualified ERISA plan were entitled to "pick and choose" among benefit options, there would be no effective way for the Insurance Commissioner to review whether the "optioning" was legal in a given instance. Without impugning the integrity of insurers or the insurance industry as a whole, there would be a substantial potential for abuse because unscrupulous competitors will write group health contracts without concern for mandatory benefit regulations once they perceive that the state cannot effectively police such contracts. Many insurance companies and health care service contractors no doubt will make every effort to comply with state regulation when appropriate, but they will be dependent on the representation of purchasers as to whether a policy is for a valid ERISA plan. The purchasers may not always be truthful or, if truthful, they may not always be correct. Ultimately, state regulation of group health insurance benefits may be either impractical or impossible. Rather than retain statutes which can be at best unevenly enforced and which may mislead the public about the scope of protection afforded to them, states may abandon regulatory efforts in this area altogether.

This result would be particularly anomalous in light of the federal Health Maintenance Organization Act, 42 U.S.C. § 300e. ERISA expressly states that it does not amend, alter, modify, invalidate, impair or supersede any other federal

law. *See* § 514(d). Appellants therefore cannot argue that the mandatory minimum benefit provisions of the Health Maintenance Organization Act are preempted by ERISA. Thus, if an employer seeks to contract with a federally qualified HMO to provide ERISA plan benefits, the employer must be willing to accept a contract covering benefits such as short-term mental health services and treatment for alcohol and drug abuse or addiction. *See* 42 U.S.C. §§ 300e(b)(1) and 300e-1(1). Moreover, the employer would also have to contract for such supplemental services as the HMO might require, such as vision care, dental care and prescription drugs. *See* 42 U.S.C. §§ 300e(b)(1) and 300e-1(2). The HMO Act is specific in listing the instances in which state law governing federal HMO's is preempted. Although the Act preempts any state laws which would frustrate an HMO's ability to do business because of requirements for initial capitalization and financial reserves, 42 U.S.C. § 300e-10(a)(1)(D), no similar preemption provision exists for state laws governing minimum benefits and coverage. Appellants should be particularly hard-pressed to urge that Congress wanted no state regulation of minimum group health benefits when Congress itself, in the case of federally approved HMO's, has mandated many such benefits and has permitted consistent state regulation of further minimum benefits.

The importance of state laws regulating benefit coverage for group health insurance policies should not be underestimated; the significance of a regulatory void if states are forced

to withdraw from this area cannot be understated. The advantage of group health insurance is that the underwriting unit is the entire group rather than each individual in the unit. Group plans thus maximize the essential quality of all insurance: The ability to transfer and distribute risk of loss among many individuals. Because they enjoy certain economies of scale and the elimination of administrative costs and commissions, group policies offer lower premiums and frequently greater risk coverage. State laws mandating that all group health insurance policies provide certain specified benefits permit state officials to identify important health dangers and to distribute the risk of their occurrence among a broad pool of citizens. Through this vehicle, states can address illnesses traditionally ignored by the insurance and health care provider industry (*e.g.*, alcoholism, mental illness); they can distribute the economic risk of conditions that are expensive to treat but less common in their occurrence (*e.g.*, maxillofacial prosthetic services for infants, which result in treatment of cleft palates and similar birth defects);[8] and they can ensure availability of insurance protection to individuals who sometimes are victims of societal ostracism (*e.g.*, unmarried pregnant women).[9] States thus may tailor insurance protections to local concerns, extend those protections to more citizens, and distribute the risk of certain health dangers among the broadest pool of beneficiaries possible.

[8] *See, e.g.*, Or. Rev. Stat. § 743.119.

[9] *See, e.g.*, Or. Rev. Stat. § 743.037, App. A.

To divest states of this regulatory function, even partially, would be directly contrary to express congressional policy and to a correct state-federal balance of authority over the business of insurance. For purposes of this amicus brief, a full recitation of the historical genesis of the McCarran-Ferguson Act is neither appropriate nor necessary. Rather, it should be sufficient to observe that the Act was passed in 1945 to ensure that courts would not invalidate state laws regulating insurance on the theory that they burden interstate commerce. To this end, section 1 of the Act expressly declared the continued regulation by the several states of the business of insurance to be in the public interest; section 2(a) of the Act provided that the business of insurance should be subject to all state laws relating to the regulation of insurance; and section 2(b) of the Act declared that no act of Congress shall be construed to invalidate, impair, or supersede any state law enacted to regulate the business of insurance unless the act specifically relates to the business of insurance.

This Court has construed broadly the concept of state laws regulating the "business of insurance." The concept includes not only laws directly or indirectly governing the relationship between the insurer and insured, but also regulation of the type of policy that can be issued, its reliability, its interpretation and its enforcement. *SEC v. National Securities, Inc.*, 393 U.S. 453, 460 (1969).

In the years since its enactment, the language of the McCarran-Ferguson Act has not been changed signifi-

cantly. Similarly, the congressionally declared policy of state primacy in the area of insurance regulation has not been diluted even slightly. The reasons for striking the state-federal balance of authority in favor of local regulation and control remain compelling. ERISA reinforces the policy of state primacy rather than questions it by its so-called "savings clause," section 514(b)(2)(A). That clause expressly and unequivocally declares that the ERISA provisions shall not be construed to exempt or relieve any person from any state law regulating insurance. Together, the McCarran-Ferguson Act and section 514(b)(2)(A) of ERISA manifest an unmistakable acknowledgment that the regulation of insurance remains a vital state concern and that it is broadly in the public interest for states to play an active and primary regulatory role.

ERISA preemption of state-mandated benefits for group health insurance would undermine this manifestation of congressional intent. Moreover, if states withdraw from this area of insurance regulation altogether because of difficulty in enforcing a de facto dual regulatory scheme, the congressional policy favoring state insurance regulation would be more seriously breached than appellants' arguments first suggest. Those arguments therefore forcefully should be rejected.

II. Many state regulations governing group health insurance coverage do not mandate particular benefits, and thus have no potential to increase significantly the cost of insuring an ERISA plan.

This case involves a challenge to the Massachusetts law mandating mental health coverage under certain group or

blanket health care insurance policies. Because this statute requires coverage that might not otherwise be provided by an ERISA plan, both appellants and their amicus have attempted to argue that such state laws severely burden ERISA plans with added costs.[10] This cost impact argument was found by the Massachusetts trial court to be speculative and wholly unsupported by the evidence.[11] It therefore should not concern this Court in resolving the issue presented.

Nevertheless, whatever the worth of the cost impact argument, it falls of its own weight when tested against other types of state regulatory provisions. Oregon has several laws that focus on reimbursement to specific classes of providers rather than on the requirement that certain services be covered by a group insurance policy. We assume such statutes are not unique to Oregon. Indeed, the Federal Health Maintenance Act, *supra*, contains provisions allowing HMO's to provide services through professionals, other than physicians, licensed by a state to provide covered services. *See* 42 U.S.C. § 300e-1(1), (2). These types of statutes, in effect, merely require reimbursement to professionals licensed to perform certain health care services if a policy would reimburse a physician for the same service; they do not themselves require that particular health care services be covered by a policy.

Oregon has several examples of this type of regulatory provision. Psychologists must be reimbursed when they pro-

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[10] *See* Appellants' Br. pp. 23-26 and *see generally* Amicus Brief for the Trustees of Local 16.

[11] *See* J.S. App. 54a-55a.

vide a service within the scope of their professional license if the service is one covered by the terms of a group health insurance policy. Or. Rev. Stat. § 743.123. Reimbursement is not dependent upon referral by a physician. Oregon law also provides that covered services within the scope of practice of a licensed nurse practitioner must be reimbursed whether the service is performed by a physician or by a nurse practitioner. Or. Rev. Stat. § 743.128. Additionally, in Oregon, if a policy covers services within the scope of practice of a licensed clinical social worker, the insured may, upon referral by a physician or psychologist, obtain the service from a licensed clinical social worker and be reimbursed. Or. Rev. Stat. § 743.135. This last statute is among the three challenged by the plaintiffs in *Hill v. Driscoll*, on an ERISA preemption theory. Because other statutes operate similarly to mandate payment for the services of state hospital or community mental health programs (Or. Rev. Stat. § 743.116), services of optometrists (Or. Rev. Stat. § 743.117), and services of denturists (Or. Rev. Stat. § 743.132), a significant number of Oregon statutes will be preempted if the Oregon plaintiffs prevail.[12]

Regulations of this type, however, do not establish minimum benefit coverage and cannot be challenged as burdensome to the cost structure of an ERISA plan. Provider reimbursement statutes like these in Oregon do not force an

[12] The relevant texts of these statutes are set out in Appendix A.

insured to seek insured health services from a specific category of provider (*e.g.*, a clinical social worker rather than a psychologist; a denturist rather than a dentist); they merely permit the insured the option to do so. There is no reason to believe that the cost of health benefits or their scope will be increased. Indeed, if anything, allowing insurance beneficiaries the option of going to licensed health care professionals other than physicians likely is cost-effective. Enactment of regulation of this type promotes the state's interest in the integrity of its licensing scheme for health care professionals. Neither ERISA plan trustees, insurance companies nor other health care service contractors (*e.g.*, Blue Cross/Blue Shield) should be permitted to use provider restrictions in health care policies to favor some professions over others, with the possible practical effect of driving certain providers out of the market and overriding a state's professional licensing scheme.

We recognize that the controversy currently before the Court does not involve statutes of this nature. Nevertheless, as the Oregon litigation demonstrates, they are subject to the same sort of ERISA preemption challenge as is made against the Massachusetts law mandating mental health coverage. In resolving the Massachusetts case, it is appropriate for this Court to be aware of the full depth, breadth and variety of state regulation that possibly will be affected by the Court's decision. Appellants' ill-supported assertions that mandatory benefit regulations impose burdensome costs on ERISA plans

are wholly inapplicable to state provider reimbursement regulations, and perhaps other forms of state insurance regulations as well.

We therefore urge this Court to consider the full range of state insurance laws potentially affected by the Court's decision and to craft its decision accordingly. Alternatively, we urge the Court to tailor its decision carefully to the specific type of statute before it and to make express the circumscribed scope of its holding.

CONCLUSION

Directly at stake in this case is state authority to regulate group health insurance coverage when an insurance policy is purchased to provide health care under an ERISA benefit plan. Potentially at stake is the practical ability of states to administer and to enforce state laws ensuring specific types of health care protection in group policies if to do so requires them to distinguish between ERISA and non-ERISA purchasers. Finally, implicated in this case is the validity of many other state laws, such as provider reimbursement provisions, which regulate group health insurance policies in distinguishable ways, and thus present distinguishable policy considerations. The effect of the appellant insurance companies' preemption argument would be far reaching and would seriously interfer with state prerogatives in the regulation of insurance. That effect is squarely contrary to declared congressional intent and to sound national policy. The broad ERISA preemption argument presented therefore should be

rejected and the judgment of the Massachusetts court should be affirmed.

Respectfully submitted,

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APPENDIX A
SELECTED OREGON REVISED STATUTES
INSURANCE POLICIES

743.037 Nondiscriminatory health insurance coverage for women. Each policy of health insurance shall provide:

(1) The same payments for costs of maternity to unmarried women that it provides to married women, including the wives of insured persons choosing family coverage; and

(2) The same coverage for the child of an unmarried woman that the child of an insured married person choosing family coverage receives.

743.116 Reimbursement for services performed by state hospital or state approved program. No policy of health insurance shall exclude from payment or reimbursement losses incurred by an insured for any covered service because the service was rendered at any hospital owned or operated by the State of Oregon or any state approved community mental health program.

743.117 Reimbursement for services of optometrist. (1) Notwithstanding any provision of any policy of health insurance, whenever such policy provides for reimbursement for any service which is within the lawful scope of practice of a duly licensed optometrist, the insured under such policy shall be entitled to reimbursement for such service, whether such service is performed by a physician or duly licensed optometrist. Unless such policy shall otherwise provide, there shall be no reimbursement for ophthalmic materials, lenses, spectacles, eyeglasses or appurtenances thereto.

(2) The provisions of this section shall not apply to any policy in effect upon September 13, 1967.

743.123 Reimbursement for services provided by psychologist. Whenever any provision of any individual or group health insurance policy or contract provides for payment or reimbursement for any service which is within the lawful scope of a psychologist licensed under ORS 675.010 to 675.150:

(1) The insured under such policy or contract shall be free to select, and shall have direct access to, a psychologist licensed under ORS 675.010 to 675.150, without supervision or referral by a physician or another health practitioner, and wherever such psychologist is authorized to practice.

(2) The insured under such policy or contract shall be entitled to have payment or reimbursement made to him or on his behalf for the services performed. Such payment or reimbursement shall be in accordance with the benefits provided in the policy and shall be the same whether performed by a physician or a psychologist licensed under ORS 675.010 to 675.150.

743.128 Reimbursement for services of nurse practitioner. (1) Whenever any policy of health insurance provides for reimbursement for any service which is within the lawful scope of practice of a duly licensed and certified nurse practitioner, including prescribing or dispensing drugs, the insured under the policy is entitled to reimbursement for such service whether it is performed by a physician licensed by the

Board of Medical Examiners for the State of Oregon or by a duly licensed nurse practitioner.

(2) This section does not apply to group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Health Maintenance Organization Act.

743.132 Reimbursement for services of denturist. Notwithstanding any provisions of any policy of insurance covering dental health, whenever such policy provides for reimbursement for any service which is within the lawful scope of practice of a denturist, the insured under such policy shall be entitled to reimbursement for such service, whether the service is performed by a licensed dentist or a certified denturist. This section shall apply to any policy covering dental insurance which is issued after July 1, 1980. Policies which are in existence on July 1, 1980, shall be brought into compliance on the next anniversary date, renewal date, or the expiration date of the applicable collective bargaining contract, if any, whichever date is latest.

743.135 Reimbursement for services of clinical social worker. Whenever any individual or group health insurance policy provides for payment or reimbursement for any service which is within the lawful scope of service of a clinical social worker registered under ORS 675.510 to 675.610:

(1) The insured under the policy shall be entitled to the services of a clinical social worker registered under ORS 675.510 to 675.610, upon referral by a physician or psychologist.

(2) The insured under the policy shall be entitled to have payment or reimbursement made to the insured or on behalf of the insured for the services performed. The payment or reimbursement shall be in accordance with the benefits provided in the policy and shall be computed in the same manner whether performed by a physician, by a psychologist or by a clinical social worker, according to the customary and usual fee of clinical social workers in the area served.

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF OREGON

MILTON R. HILL, RICHARD J. MIXER, LEONARD ROTHENBERGER, JAMES A. ARCHER, DOUGLAS McQUOWN, and RICHARD RALSTON, Trustees of Sheet Metal Workers Local 16 Health & Welfare Trust,	)	Civil No. 84-287
Plaintiffs,	)	ORDER
v.	)	
JOSEPHINE M. DRISCOLL, Insurance Commissioner of the State of Oregon, and BLUE CROSS AND BLUE SHIELD OF OREGON, a corporation,	)	
Defendants.	)	

This is an action for declaratory and injunctive relief brought by the trustees of the Sheet Metal Workers Local 16 Health and Welfare Trust (the Trust). Established by a collective bargaining agreement, the Trust receives contributions from employers pursuant to an employee benefit plan (the Plan). The Plan is an employee welfare benefit plan under the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001 *et seq.*

Defendant Josephine Driscroll is the insurance commissioner for the state of Oregon. Defendant Blue Cross and Blue Shield of Oregon (Blue Cross) is a corporation that sells and issues group insurance policies. Blue Cross is an authorized health care service contractor subject to state regulation.

The Oregon insurance code requires that group health insurance policies contain coverage for: 1) treatment of chemical dependency, including alcoholism; 2) services by a registered clinical social worker; and 3) maxillofacial prosthetic devices. Or. Rev. Stat. §§ 743.110 [*sic*], 743.135, 743.557. The benefits provided by the Plan do not include coverage as required by these provisions. The trustees of the Plan wish to provide health care coverage under the Plan by purchasing a group health insurance policy from Blue Cross, but Blue Cross maintains that any policy it issues must contain the mandated coverage.

The plaintiffs seek a judgment declaring that, on the basis of federal preemption by ERISA, the Plan, the Trust and the trustees are not subject to the mandated insurance coverage of the Oregon statutes. The plaintiffs also seek an order restraining the insurance commissioner from attempting to require the Plan to provide the mandated insurance coverage. The defendants contend that all group policies sold by authorized insurers must comply with the Oregon statutes, regardless of whether the purchaser of a group policy is an ERISA plan. Both parties move for summary judgment.

Discussion

The preemption provisions of ERISA are found at 29 U.S.C. § 1144. The general preemption clause states that ERISA supersedes "any and all state laws insofar as they . . . relate to any employee benefit plan." 29 U.S.C. § 1144(a).

The general preemption clause is modified by a "savings clause" that affirms state authority to regulate insurance. The savings clause exempts from preemption any state law that "regulates insurance." 29 U.S.C. § 1144(b)(2)(A).

The savings clause is in turn limited by the "deemer clause," which provides that a state may not deem a benefit plan to be an insurance company or other insurer or to be engaged in the business of insurance in order to subject a plan to state insurance regulation. 29 U.S.C. § 1144(b)(2)(B).

The issue presented here requires analysis as follows: 1) whether the Oregon statutes "relate to" the Plan and so are subject to the general preemption clause; 2) if so, whether the statutes are exempt from preemption under the savings clause as laws which "regulate insurance;" and 3) if so, whether the deemer clause requires preemption nevertheless.

The defendants concede that the statutes at issue here "relate to" employee benefit plans and are subject to the general preemption clause. However, the defendants contend that the Oregon statutes are laws which "regulate insurance," expressly exempted from preemption by the savings clause.

ERISA contains no definition of the phrase "regulate insurance." However, in *SEC v. National Securities, Inc.*, 393

U.S. 453-(1969) the Supreme Court defined the scope of state laws "regulating the business of insurance" as those which deal with "[t]he relationship between insurer and insured, *the type of policy which could be issued*, its reliability, interpretation and enforcement. *Id.* at 459-60 *Quoted in Eversole v. Metropolitan Life Ins. Co.*, 500 F. Supp. 1162 (C.D. Cal. 1980) (emphasis added).

The Oregon statutes are directed solely at insurance companies and govern the terms of insurance policies. The statutes are laws which "regulate insurance" and are subject to the savings clause.

The conflict between preemption of the statutes by the general preemption clause and exemption under the savings clause must be resolved by application of the deemer clause.

The deemer clause restricts application of the savings clause by prohibiting the state from deeming a benefit plan to be an insurer in order to subject the plan to insurance regulation. On its face, the deemer clause does not forbid insurance regulation which has only an indirect effect on employee benefit plans. However, some courts have held that there is no difference between direct and indirect regulation of employee benefit plans, and that both types of regulation are proscribed by ERISA. *See, e.g., United Food and Commerical Workers Unions v. Baerwaldt*, 572 F. Supp. 943 (E.D. Mich. 1983).

But I find more persuasive the court's analysis in *Wadsworth v. Whaland*, 562 F.2d 70 (1st Cir. 1977), *cert. denied*, 435 U.S. 980 (1978). In *Wadsworth*, the court held that a New Hampshire statute which required that issuers of

group health insurance policies provide coverage for the treatment of mental and emotional illnesses was not preempted by ERISA. The court reasoned that a construction of the deemer clause which barred even insurance regulation with an indirect effect on employee benefit plans would render the savings clause surplusage. 562 F.2d at 78. In *Eversole*, *supra*, the court arrived at the same conclusion. The *Eversole* court emphasized the "fundamental" distinction between laws regulating an employee benefit plan and laws regulating the insurance company from which the plan purchases insurance. 500 F. Supp. at 1169. *See also, Hewlitt-Packard Co. v. Barnes*, 571 F.2d 502, 504-05 (9th Cir.), *cert. denied*, 439 U.S. 831 (1978) (direct regulation of employee benefit plans prohibited). The *Eversole* court noted that since only insurance laws that "relate to" employee benefit plans are even subject to ERISA preemption, "if insurance regulation which has an indirect effect on employee benefit plans is preempted by the deemer clause, what is left for the savings clause to save?" *Id*; *McLaughlin v. Connecticut General Life Ins. Co.*, 565 F. Supp. 434, 443 (N.D. Cal. 1983) (adopting *Wadsworth*, and *Eversole* analysis).

When interpreting an act of Congress, the court is required to construe it so as to give effect to all its parts. *See e.g., McDonald v. Thompson*, 305 U.S. 263 (1938). I therefore conclude that Or. Rev. Stat. § 743.110 [*sic*], 743.135, and 743.557 are not preempted by ERISA.

IT IS ORDERED that plaintiffs' motion for summary judgment is denied. Defendants' motion for summary judgment is allowed.

Dated this 7th day of September, 1984.

[Signature omitted in printing]

APPENDIX C

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

MILTON R. HILL, et al.,	)	No. 84-4223
	)	
Plaintiffs-Appellants,	)	DC# CV-84-287 EL
	)	Oregon (Portland)
vs.	)	
	)	
	)	
JOSEPHINE M. DRISCOLL, Insurance Commissioner of the State of Oregon, et al.,	)	ORDER
	)	
	)	
	)	
	)	
Defendants-Appellees.	)	
	)	

On November 29, 1984, a Prebriefing Conference was held before Conference Attorney Randall G. Knox. Plaintiffs were represented by James Clarke. The State of Oregon was represented by Linda DeVries. Blue Cross was represented by Jack Hoffman.

This appeal is stayed until June 1, 1985 or pending the Supreme Court's disposition of *Travelers Insurance Co. v. Commonwealth*, 84-356, (probable jurisdiction noted), whichever occurs first.

Plaintiffs shall contact the Conference Attorney upon expiration of the stay to schedule a further prebriefing conference, if necessary.

This order is subject to reconsideration by a judge if any objection is filed within 10 days of the entry of the order.

[Signature omitted in printing]

(24) (20)

Nos. 84-325 and 84-356

Office-Supreme Court, U.S.
FILED
JAN 25 1985
ALEXANDER L. STEVAS,
CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

METROPOLITAN LIFE INSURANCE COMPANY,
Appellant,

v.

COMMONWEALTH OF MASSACHUSETTS,
Appellee.

THE TRAVELERS INSURANCE COMPANY,
Appellant,

v.

COMMONWEALTH OF MASSACHUSETTS,
Appellee.

On Appeals From the Supreme Judical Court For The Commonwealth Of Massachusetts

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BRIEF OF AMICI CURIAE AMERICAN PUBLIC HEALTH ASSOCIATION, AMERICAN ACADEMY OF PEDIATRICS AND SKIP OF NEW YORK, INC. IN SUPPORT OF APPELLEE

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Nos. 84-325 and 84-356

In The

SUPREME COURT OF THE UNITED STATES

October Term, 1984

METROPOLITAN LIFE INSURANCE COMPANY,
Appellant

v.

COMMONWEALTH OF MASSACHUSETTS,
Appellee

THE TRAVELERS INSURANCE COMPANY,
Appellant

v.

COMMONWEALTH OF MASSACHUSETTS,
Appellee

On Appeals from the Supreme Judicial Court for the Commonwealth of Massachusetts

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BRIEF OF AMICI CURIAE AMERICAN PUBLIC HEALTH ASSOCIATION, AMERICAN ACADEMY OF PEDIATRICS AND SKIP OF NEW YORK, INC. IN SUPPORT OF APPELLEE

INTERESTS OF AMICI CURIAE

American Public Health Association

The American Public Health Association ("APHA"), founded in 1872, is the oldest and largest professional public health society in the world, with a combined national and affiliate membership of over 50,000 health professionals. APHA members include physicians, dentists, nurses, social workers, health planners and administrators, officials and employees of federal, state and local public health agencies, and other health professionals.

APHA strives to promote the health of the American people by promoting the availability of health services, encouraging a safe and healthful environment, launching public health education programs, and publishing numerous materials reflecting developments in public health.

APHA has advocated comprehensive health services and has urged public recognition that mental and physical health are related and that the physical health of the population cannot be maintained without the availability of mental health services. To this end, APHA has urged governmental action to insure the availability of outpatient mental health services.

American Academy of Pediatrics

The American Academy of Pediatrics is a not-for-profit Pan-American association of 24,000 board-certified pediatricians possessing at least five years of specialized study or practice in pediatrics. The overall objective of the Academy is to maximize the quality of medical care available to children.

In 1973, the Academy, with the assistance of the Health Insurance Association of America, developed the Model Newborn Children Bill. The Model Bill requires any

health insurance policy that covers children of an insured to cover newborns from birth. All fifty states have now adopted laws embodying the substance of the Model Bill.

SKIP of New York, Inc.

SKIP of New York, Inc., a New York non-profit corporation, assists families of chronically ill and disabled children and ventilator-dependent adults in obtaining necessary health and social services. SKIP assists families in arranging for children to be cared for in their homes rather than hospitals. State laws which mandate home health care benefits in health insurance policies are vital to SKIP's mission of facilitating the integration of disabled children into family life. In addition, SKIP is concerned with maintaining state laws and regulations requiring health insurance coverage of dependent children from the date of birth and prohibiting the

exclusion from coverage of congenital conditions and illnesses.[1]

SUMMARY OF ARGUMENT

The states, exercising traditional powers to regulate the substantive content of insurance policies, have mandated the inclusion of minimum levels of benefits in all health insurance policies issued in their jurisdictions. These laws have assured millions of Americans of health insurance coverage for newborn children, out-patient mental health services, drug and alcohol abuse treatment, home health care and the services of numerous health care professionals.

When it enacted ERISA, Congress specifically exempted from federal preemption state laws which regulate insurance.

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[1] The parties have consented to the filing of this brief. Copies of their letters of consent have been filed with the Clerk of the Court, pursuant to Rule 36.2.

In creating this exemption, Congress was certainly mindful of the role that the states had traditionally played to protect insureds by regulating the substantive content of health insurance policies. Subsequent to ERISA's enactment, Congress, the Department of Labor, the Solicitor General and a number of courts have all concurred in the view that it was not Congress' intent to nullify powers exercised by the states to protect insureds from risks of health care expenses which the states, as a matter of public policy, have determined to be intolerable.

That the states are prevented from similarly regulating the benefits offered by self-insured employee benefit plans cannot justify depriving the states of their power to regulate the content of health insurance policies which are properly within their regulatory jurisdiction.

Congress intended to balance the burdens of compliance against the protections to be afforded employees. ERISA recognized that protections afforded employees under state law may outweigh ease of administration and uniformity of benefits in that balance.

That health insurance benefits are a mandatory subject of collective bargaining does not foreclose the states from legislating minimum acceptable levels of benefits in health insurance policies purchased by employee benefit plans. The enactment of state laws regulating hours, wages and working conditions has not been found to unduly restrict the collective bargaining process or otherwise interfere with federal labor policy objectives.

Congress has reserved to the states the regulation of the business of insurance. The level of benefits provided in an insurance policy constitutes an

integral part of the business of insurance which Congress intended to leave for state regulation. Neither ERISA nor federal labor policy indicates an intent to alter the boundary Congress has set for permissible state regulation.

ARGUMENT

I. IN EXEMPTING FROM ERISA'S PREEMPTION STATE LAWS WHICH REGULATE INSURANCE, CONGRESS INTENDED TO PRESERVE FOR EMPLOYEES THE PROTECTIONS WHICH STATE LAWS HAVE TRADITIONALLY AFFORDED THOSE INSURED BY GROUP HEALTH POLICIES.

At issue in these appeals is the continued vitality of protections, mandated by state law, which millions of Americans have come to rely upon as part of their health care insurance. Acceptance of appellants' argument would result in nullifying a power which the states have exercised to guarantee to insureds in their states a minimum acceptable level of health insurance and other insurance benefits, without any substitution of federal regulatory protection.

Each of the fifty states and the District of Columbia has exercised this power in one respect or another to regulate the substantive content of health insurance policies offered to employees in their jurisdictions. By mandatory legislation, the states have sought to close gaps in existing health care coverage and to secure for employees adequate insurance protection, inter alia, for newborns, the handicapped and others who would be overlooked by the unregulated operation of the insurance marketplace. If the states are prohibited from enacting required minimum benefits, a regulatory void would exist in which employees may be exposed to risks of health care expenses that, as a matter of policy, the states have determined to be unacceptable.

Section 514 of ERISA is a complex statement of Congress' intended delineation of the respective authorities of the

federal and state governments to regulate employee benefit plans. Speaking broadly, Congress explicitly stated that ERISA was to preempt any state laws that "relate to" employee benefit plans. 29 U.S.C. § 1144(a). Simultaneously, however, Congress carved out exceptions to the general principle of federal preemption for permissible state regulation. Id. § 1144(b). As to these excepted areas of state interest, the otherwise broad rule of preemption has no application. See Shaw v. Delta Air Lines, Inc., 103 S. Ct. 2890 (1983). These appeals focus upon the "savings" clause, the exception in which Congress declared that ERISA should not "be construed to exempt or relieve any person from any law of any State which regulates insurance". 29 U.S.C. § 1144(b)(2)(A).

A. States Have Traditionally Regulated Insurance Benefits Under Their Police Powers

The regulation of insurance is a necessary and proper exercise of a state's police power. See, e.g., Blue Cross v. Commonwealth, 269 S.E.2d 827, 835-37 (Va. 1980). In appellants' view, the traditional role of the states in insurance regulation has been, and should be, limited to: (i) the supervision of the insurance carriers themselves, including regulations such as minimum capitalization requirements, criteria for the investment of funds and character standards for insurance company management; and (ii) the regulation of business practices in the selling of insurance, including the licensing of agents and brokers, setting standards of conduct for sales and advertising, and rate-making.

In addition to these areas, however, the states have traditionally exercised their police power to regulate the

substantive content of insurance contracts, including the scope of coverage and benefits offered. See generally Insurance Commissioner v. Metropolitan Life Insurance Co., 296 Md. 334 (1983) and cases cited therein; Brummond, Federal Preemption of State Insurance Regulation under ERISA, 62 Iowa L. Rev. 57, 83-84 (1976). This form of regulation is in furtherance of the state's interest in assuring that insureds are treated fairly and equitably by insurance carriers. Regulation of the content of insurance policies "may be regarded as ensuring that the insured gets what he pays for, or - going somewhat further - as requiring the company to give the insured what he must have assumed he was paying for." Kimball, The Purpose of Insurance Regulation: A Preliminary Inquiry in the Theory of Insurance Law, 45 Minn. L. Rev. 471, 491 (1961).

The states regulate the content of a wide variety of insurance contracts through statutes mandating the minimum acceptable scope of coverage.[2] Provisions of insurance contracts which are so familiar as to appear commonplace, in fact, have their origins in state regulation.[3] In addition, states confer upon regulatory officials broad authority to disapprove policies that are inequitable, misleading or unreasonable in relation to the premium

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[2] See, e.g., N.Y. Ins. Law §§ 3220 (group life), 3221 and 4235 (group accident and health), 3216 (individual accident and sickness), 3420 (liability), and 3404 (fire) (McKinney Supp. 1984).

[3] For example, state statutes mandate the inclusion of clauses in life insurance policies that limit exclusions from coverage for death by suicide to those occurring within two years of the issuance of the policy. See, e.g., Md. Code, Art. 48A; § 410(a)(5) (1979); N.Y. Ins. L. § 3202(b)(1)(B) (McKinney Supp. 1984). State statutes also mandate minimum levels of uninsured motorist coverage in automobile insurance policies. See, e.g., Md. Code, Art. 48A, § 541(c)(2)(1979); N.Y. Ins. L. § 5103 (McKinney Supp. 1984).

charged.[4]

The states utilized this power to govern the content of health insurance policies prior to the enactment of ERISA.[5] Appellants' arguments that state-mandated benefit laws are of recent creation, designed to usurp power in contravention of federal policy, and a departure from the historic and proper regulatory function of the states is contrary to historical fact. Among the earlier forms of mandatory benefit laws adopted by the states were laws requiring that policy coverage of minors continue beyond the maximum age limit

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[4] See, e.g., Ill. Rev. Stat., ch. 73, § 755(2) (1965); N.Y. Ins. L. § 3201 McKinney Supp. 1984).

[5] For example, in 1958, New York mandated that group health insurance policies contain a provision permitting an individual who terminated his employment to convert the policy into an individual policy which must include specified minimum levels of coverage. See N.Y. Ins. L. § 3221 (McKinney Supp. 1984) (recodifying N.Y. Ins. L. § 162(5) (McKinney 1966)).

(usually 19) where those dependents are incapable of self-sustaining employment because of

mental or physical handicap and are chiefly dependent upon the subscriber for support.[6]

Another manner in which the states have exercised this power is to require that group health insurance coverage for infants commence from the moment of birth. The need for such legislation grew out of the fact that a significant number of family health insurance policies excluded newborn infants from coverage for

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[6] See Table II in the Appendix to this brief. The Appendix to the Brief of Amicus Curiae Health Insurance Association of America in Support of Jurisdictional Statements surveys the wide variety of benefits mandated by state laws which include: outpatient mental health services, drug and alcohol abuse treatment, home health care and the services of numerous health care professionals. That survey, however, omits two forms of coverage mandated by state law which are of particular interest to these amici: mandatory coverage of newborns from birth and mandatory coverage of mentally or physically handicapped dependents.

the first fourteen to thirty days of their lives. Schulkind, Morrisey & Morton, Neonatal Health Insurance, 13 Clinical Pediatrics 209 (Mar. 1974) (hereinafter cited as Schulkind); J.A. at 346, 454. Immediate coverage of newborns usually could have been obtained if requested; however, the average insurance buyer was unaware of either the newborn exclusion or of the option to have the newborn included.[7] Schulkind, supra at 209. Since more infants die in the first seven days of life than in the remainder of the first year of life, those insurance policies failed to give protection during the interval of greatest risk. Benfield, The Newborn Health Insurance

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[7] Union members whose insurance policies were the product of collective bargaining were not immune from the surprise of discovering their newborn's medical expenses were not covered. See Benfield, The Newborn Health Insurance Exclusion Clause Eradicated in Ohio, 15 Clinical Pediatrics 19 (Jan. 1976).

Exclusion Clause Eradicated in Ohio, 15 Clinical Pediatrics 19 (Jan. 1976). Faced with a newborn who was premature or sick, parents without insurance coverage for the child were required to take on debts of burdensome magnitude and even become dependent on the state for support. See Schulkind, supra at 210; J.A. at 454.[8] In addition, because coverage did not begin

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[8] The sponsor of the New York legislation mandating coverage of newborns from birth viewed the purpose of this legislation as being to "provide a more comprehensive and fair family heath insurance plan for insured families within the state." 1977 New York State Legislative Annual 214. Mandatory coverage was necessary because:

> [p]resently family plans do not cover new born infants until 10-days from birth. Thus if the child is born with a birth defect or malady the family must bear the medical costs. This situation can severely burden the financial well-being of the family for some time to come and also the physical well-being of the child.

Id.

from the moment of birth, a family might also learn that there would be no coverage for the treatment of a child who was congenitally ill since this was a "pre-existing condition", antedating the policy's coverage.

In November 1973, the American Academy of Pediatrics, with the assistance of the Health Insurance Association of America, developed the Model Newborn Children Bill which required that health insurance coverage be extended to infants from the moment of birth. Since that time, every state has mandated coverage affording protections similar to the Model Bill. See Appendix, Table I.

The protections accorded by state laws mandating the coverage of newborns from birth have grown increasingly important. Advances in neonatal pediatric medicine have made it possible for infants born with life-threatening conditions to

survive. Infants born prematurely, weighing no more than two pounds at birth now have the potential for survival. These ever increasing technological capacities create enormous opportunities, but at enormous costs. An estimated 6% of live-born infants are treated in a neonatal intensive care unit, where the length of stay averages 8-18 days. In 1978, $1.5 billion was spent on neonatal intensive care unit care. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment 204 (Mar. 1983). The hospital costs of a newborn with a birth defect run from $800 to $1,000 a day, with doctor bills adding another $200 to $400 daily. A sixty day confinement for a relatively simple to treat but common infant ailment like bacterial pneumonia costs $50,000 to $60,000. A single claim for a premature child with heart and respiratory

problems came to $707,000. N.Y. Times, Dec. 9, 1984, at F11, col. 3.[9] In the absence of state laws mandating coverage during this high risk period of life, insurers may revert to the prior practice of excluding newborns from health insurance coverage.

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[9] Although the cost of neonatal care is enormous, a relatively small number of families are involved. Mutual of Omaha estimates that only one in 10,000 claims exceeds $50,000. N.Y. Times, Dec. 9, 1984, at F11, col. 3. These costs are inconsequential in the broad health care delivery system in which more than 400 billion dollars will be spent in 1985. The coverage of neonatal medical treatment fits squarely within the objective of insurance of spreading and socializing a risk. See Kimball, supra, 45 Minn. L. Rev. at 512-514.

B. Since Federal Law Does Not Address Minimum Levels of Health Insurance Benefits, State Laws Are Not to be Preempted Since That Woudl Create an Undesirable Regulatory Void.

Congress was fully aware of how instrumental insurance was to the operation of employee benefit plans. This understanding was reflected in, inter alia, the statutory definition of an employee benefit plan as one providing benefits "through the purchase of insurance or otherwise." 29 U.S.C. § 1002(1).

"When ERISA was enacted, . . . Congress certainly knew that much of the body of state law regulating insurance concerned required coverages in various categories of insurance." Insurance Commissioner v. Metropolitan Life Insurance Co., 296 Md. 334, 340 (1983). Yet, Congress laid down a broad exemption from the

general principle of federal preemption for "any law of any State which regulates insurance." 29 U.S.C. § 1144(b)(2)(A).[10]

Since the regulation of insurance is primarily a state function, the court below made a reasonable and correct analysis of the inter-relationship of state and federal law.

> Where . . . the field which Congress is said to have pre-empted has been traditionally occupied by the States, . . . "we start with the assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress."

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[10] Indeed, to say that the savings clause does not apply to state laws regulating insurance policies sold to ERISA plans would render the saving clause meaningless. Obviously, only those policies which are sold to employee benefit plans could, in the first instance, be preempted under § 514(a). There is no need to "save" an insurance regulation which does not "relate" in any way to an employee benefit plan.

Jones v. Rath Packing Co., 430 U.S. 519, 525 (1977) (quoting Rice v. Santa Fe Elevator Corp., 331 U.S. 218, 230 (1947)). Since Congress expressly exempted state laws regulating insurance from the preemption it otherwise mandated, it was appropriate for the court below to apply general principles flowing from the Supremacy Clause and infer federal preemption only to the extent that there was a clear conflict between state and federal law. See, e.g., Silkwood v. Kerr-McGee Corp., 104 S.Ct. 615 (1984); DeCanas v. Bica, 424 U.S. 351 (1976); Florida Lime and Avocado Growers, Inc. v. Paul, 373 U.S. 132 (1963).[11] Since ERISA does not purport to

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[11] The Court below did not, as appellants contend, resurrect the "conflict-based" analysis rejected by this Court in Shaw, 103 S. Ct. at 2900-01. The portion of the Shaw opinion referred to focused on the reading to be given to Congress' express declaration of preemption in § 514(a). Since Congress specifically exempted insur-

Footnote continued

address required levels of health insurance benefits, Shaw v. Delta Air Lines, Inc. 103 S. Ct 2890, 2897 (1983), it is apparent that there is no conflict between state and federal law. To say that the states may not regulate the content of health insurance policies even where federal law does not address minimum benefits is to create an unacceptable regulatory void, which Congress cannot be assumed to have intentionally created. See Okin, Federal Preemption of State Law Under ERISA: An Examination of the Effects of the Federal Mandate in the Light of Authoritative Precedent Under the Supremacy Clause, the McCarran-Ferguson Act and the Legislative History, 24 Ass'n of

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ance regulation from the rule of preemption that it expressly created in § 514(a), the court below did not commit error in employing the analysis it did to determine whether preemption should be implied in § 514(b); that is, whether the state enactment conflicts with federal law.

Life Ins. Counsel Proceedings 115, 151 (1976)[12]

C. The Executive, Legislative and Judicial Branches of Government Have Concurred That ERISA's Enactment Did Not Deprive the States of Their Authority to Regulate the Content of Health Insurance Policies.

The First Circuit has authoritatively addressed the insurance exception in section 514(b) and has held state-mandated benefit laws to be a lawful exercise of state regulation within ERISA's insurance "savings" clause. See Wadsworth v.Whaland, 562 F.2d 70 (1st Cir. 1977), cert. denied, 435 U.S. 980 (1978).[13]

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[12] The author of this article, Franklin J. Okin, was, at the time of its writing, Associate General Counsel of The Travelers Insurance Company. According to Mr. Okin, "It would be a subversion of the purposes of ERISA and national policy to say that the ERISA preemption provision was designed to create a regulatory void." Okin, supra at 151.

[13] Other courts have similarly taken the position that state statutes specifying mandatory minimum benefits in insurance policies are laws regulating insurance

Footnote continued

In Wadsworth, administrators of various health and welfare funds contended that ERISA preempted a New Hampshire law requiring issuers of group health insurance policies to include coverage for the treatment of mental illness and emotional disorders and that the state law was invalid insofar as it required employee benefit plans to purchase insurance policies that included the state-mandated coverage. Id. at 73.

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within the meaning of the "savings" clause of § 514(b)(2)(A) of ERISA. Insurance Commissioner v. Metropolitan Life Insurance Co., 296 Md. 334 (1983); Wayne Chemical, Inc. v. Columbus Agcy. Serv. Corp., 567 F.2d 692, 699, 700 (7th Cir. 1977); New Hampshire-Vt. Health Serv. v. Whaland, 119 N.H. 886 (1979); Eversole v. Metropolitan Life Ins. Co., 500 F. Supp. 1162, 1168-1170 (C.D. Cal. 1980); Cate v. Blue Cross & Blue Shield, 434 F. Supp. 1187 (E.D. Tenn. 1977); Insurers' Action Council, Inc. v. Heaton, 423 F. Supp. 921,926 (D. Minn. 1976).

The First Circuit held that, pursuant to the "savings" clause, the states were not forbidden "from affecting employee benefit plans by regulating group insurance." Id. at 78. The Court declined to interpret ERISA in a manner that "would nullify all state insurance laws concerning group insurance when the group policy is issued to an employee benefit plan" in the absence of a clear Congressional intent to so restrict "the state's primacy in regulating insurance". Id.

At this Court's invitation in its consideration of plaintiffs' petitions for a writ of certiorari in Wadsworth, 434 U.S. 1044 (1978), the Solicitor General expressed the view of the United States that a state statute mandating inclusion of mental health coverage in group health insurance policies was not intended to be preempted by ERISA. With respect to section 514(b)(2)(A), the "savings" clause

at issue here, the Solicitor General stated:

> This savings provision would be meaningless unless it saved from preemption state laws regulating insurance which also indirectly regulate employee benefit plans, since no other state law regulating insurance would be subject to preemption-under the Act even in the absence of the savings provision. [The New Hampshire law mandating mental health coverage] obviously "regulates insurance," and thus the court correctly found that Congress intended that law and others like it to remain effective regardless of ERISA's otherwise broad preemption of state laws relating to plans.

Dkt. Nos. 77-765 and 77-772, Memorandum for the United States as Amicus Curiae (hereinafter cited as "Solicitor General's Wadsworth Brief") at 7.[14]

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[14] The Solicitor General made it plain that he was also expressing the view of the Department of Labor, the executive department charged with administering ERISA. "As this Court has often recognized, the con-

Footnote continued

In 1979, following the decision in Wadsworth, Senators Williams and Javits, the sponsors of the original ERISA bill, proposed S.209, the ERISA Improvements Act of 1979. While the proposed Act primarily concentrated on remedying regulatory deficiencies in pension plan administration, section 155 of the bill would have preempted state-mandated benefit laws by adding to section 514(b)(2)(B) the following:

> A State insurance law which provides that a specific benefit or benefits must be provided or made available by a contract or policy of insurance issued to an employee benefit plan is a law which relates to an employee benefit plan within the meaning of subsection (a) and is not a law which regulates insurance within the meaning of subparagraph (A).

S.209, 96th Cong., 1st Sess. § 155, 125 Cong. Rec. 937 (1979). According to Senator Javits, the proposed amendment to section 514 was intended to legislatively overrule the decision in Wadsworth v. Whaland. See 125 Cong. Rec. 947 (1979). The bill, however, was never enacted.[15]

Congress' failure to enact the amendment evidences its belief that the holding in Wadsworth was not contrary to

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struction of a statute by those charged with its administration is entitled to substantial deference." United States v. Rutherford, 442 U.S. 544, 553 (1979). See also Board of Governors v. First Lincolnwood Corp., 439 U.S. 234, 248 (1978); Bayside Enterprises, Inc. v. NLRB, 429 U.S. 298, 304 (1977); Udall v. Tallman, 380 U.S. 1, 16 (1965).

[15] Interestingly, though, in 1979, Congress was called upon to consider state-mandated benefit laws in a different context. In that year, the Council of the District of Columbia passed a law mandating newborn coverage in group health insurance policies. The local law was transmitted to Congress for its review, pursuant to the District of Columbia Self-Government and Governmental Reorganization Act, Pub. L. No. 93-198, 87 Stat. 774 (1973). Congress did not disapprove and the enactment took effect. D.C. Code § 35-1101 (Supp. 1983).

the original intent of Congress in enacting ERISA with its exception to preemption for state insurance laws, and that therefore, no remedial legislation was necessary. See Blue Chip Stamps v. Manor Drug Stores, 421 U.S. 723, 733 (1975); Blau v. Lehman, 368 U.S. 403, 412-13 (1962). In failing to enact the amendment under the circumstances "Congress [was] not merely expressing an opinion . . . but [was] acting on what it [understood] its own prior acts to mean." Bell v. New Jersey and Pennsylvania, 103 S.Ct 2187, 2194 n. 12 (1983) (quoting Mount Sinai Hospital v. Weinberger, 517 F.2d 329, 343 (5th Cir. 1975)).

In light of the clear opportunity that Congress had to amend the preemption-provision -- if it believed Wadsworth was incorrectly decided -- its failure to enact the amendment "strongly militates against a judgment that Congress intended a result that it expressly declined to enact." Gulf

Oil Corp. v. Copp Paving Co., 419 U.S. 186, 200, (1974). Congressional failure to expand federal authority is indicative of its view of the limits to the prior legislation, as well as its reluctance to broaden that legislation. Bowsher v. Merck & Co., 103 S.Ct 1587, 1595 (1983); Bell v. New Jersey and Pennsylvania, 103 S.Ct. at 2194. See also Rostker v. Goldberg, 453 U.S. 57 (1981).

D. The States Are at Liberty to Regulate the the Content of Health Insurance Policies Available to Employee Benefit Plans as Purchasers of Insurance.

As has been shown, state laws mandating the inclusion of particular coverage is a traditional exercise of the state's authority to regulate insurance. There is no evidence that Congress meant to restrict the exercise of that power with respect to group health insurance policies purchased by an employee benefit plan.

> The fact that the purchaser of insurance is an employee benefit plan is immaterial; Congress did not intend to confer any special exemption or privilege on them as insurance buyers. Insurance sales to them must conform to the same rules as those to any other insurance buyer, and if a state determines . . . that all group health insurance sold in the state must provide coverage for mental and emotional disturbance, the plans may purchase no other.

Solicitor General's Wadsworth Brief at 8.

Appellants maintain that, since state laws may not regulate self-insured employee benefit plans, the cost of premiums for state-mandated benefits will induce some plans to self-insure to evade the obligations imposed by state law. To the extent that there has been an increase in the number of self-insured plans, that trend pre-dates the enactment of ERISA, and has developed independently of the demands placed upon employers by mandatory benefits. See Business Insurance, Mar. 10,

1975, at 4, col. 1; R. Goshay, Corporate Self-Insurance and Risk Retention Plans (1964) (cited in M.R. Greene, Risk and Insurance 78 (4th ed. 1977)). The decision of plan trustees to forego the security afforded by spreading the risk through insurance involves complex considerations, the incremental cost of premiums on the additional coverage state law requires being only a relatively small factor.[16]

The states have determined as a matter of public policy that health insurance contracts must contain certain minimum levels of protection for the insured. The creation of comprehensive national health

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[16] Except for the largest, and most stable employee benefit plans, it is unlikely that the additional premium resulting from mandated benefits will, without more, justify self-insurance. "If a firm cannot afford insurance premiums, it is even more unlikely that the firm can afford the loss should it occur, or that the firm can afford to set aside a self-insurance fund." M.R. Greene, supra at 77.

insurance may someday remove the need for these protections. In the interim, however, the states remain free within their regulatory jurisdictions to mandate minimum levels of health insurance benefits. "[R]eform may take one step at a time, addressing itself to the phase of the problem which seems most acute to the legislative mind." Williamson v. Lee Optical, 348 U.S. 483, 489 (1955). "Legislatures may implement their program step by step . . . adopting regulations that only partially ameliorate a perceived evil and deferring complete elimination of the evil to future regulations." New Orleans v. Dukes, 427 U.S. 297, 303 (1976).

If, because of ERISA's "deemer" clause, 29 U.S.C. § 1144(b)(2)(B), the states are prevented from mandating minimum levels of benefits for self-insured plans, it does not mean that they are, or should be, powerless with respect to insurance

that is within their jurisdictions. That self-insurance may become more attractive to plan administrators because of the cost of state-mandated benefits is no cause to nullify the states' lawful exercise of their police power; to do so would permit the circumvention of law to dictate the principle of law.

E. This Court Has Recognized That Uniformity of Benefits is Not an Absolute Requirement under ERISA.

Appellants, and those amici supporting their position, urge broad preemption to eliminate any differences in benefits and to ease plan administration. Although Congress was concerned with the burdens of compliance with regulation, whether federal or state, it is abundantly clear that Congress did not intend to eviscerate employee protections in the interest of easing the real or claimed burden on plan administrators. The Senate Committee Report reflects the effort to achieve a

balance of the oftentimes competing interests:

> The Bill reported by the Committee represents an effort to strike an appropriate balance between the interests of employers and labor organizations in maintaining flexibility in the design and operation of their pension programs, and the need of the workers for a level of protection which will adequately protect their rights and just expectations.

S. Rep. No. 127, 93d Cong., 1st Sess. 13 (1973), reprinted in 1974 U.S. Code Cong. & Ad. News 4850.

Shaw v. Delta Air Lines, Inc., 103 S. Ct 2890 (1983), recognized that considerations of uniformity of benefits and ease of administration do not perforce outweigh the protection of state-mandated benefits in that balance. In Shaw, multi-state employers and an insurer challenged, inter alia, the legality of the New York Disability Benefits Law which mandated that

employers provide the same sick-leave benefits to employees unable to work because of pregnancy as for any other disability. This Court found that the Disability Benefits Law was not preempted by ERISA since it came within section 514(b)(3)'s exception for employee benefit plans maintained "solely" for purposes of complying with state disability insurance laws. Id. at 2905. This Court held that

> a state may force the employer to choose between providing disability benefits in a separately administered plan and including the state-mandated benefits in its ERISA plan. If the State is not satisfied that the ERISA plan comports with the requirements of its disability insurance law, it may compel the employer to maintain a separate plan that does comply.

Id. at 2906.

Shaw's effect is to subject a multi-state employer to the very sort of non-uniformity of benefits that appellants

claim is anathema to ERISA and requires the preemption of all state-mandated benefit laws. Under Shaw, plan administrators are not to be relieved of their obligation to comply with the laws of the respective states and provide the coverage those states require. Although these laws are in some instances conflicting as to the scope of their coverage, ERISA does not require their preemption. There is no demonstrable reason why differences in state law as to mandatory health insurance coverage should require a different result.[17]

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[17] The difference in coverage which state law may require is illustrated by the rulings of the various states on claims of disability caused by on-the-job stress, without any physical injury. For example, McGarrah v. State Accident Insurance Fund, 296 Or. 145 (1983), held that under the Oregon State Workers' Compensation Law, "stress-caused claims for benefits arising out of mental and physical disorders are compensable if they flow from the conditions of the worker's employment, providing causation . . . has been proven." Id. at 163. Accord Haydel v. Sears, Roebuck &

Footnote continued

Footnote continued from previous page

Co., No. 47619 (N.Y. Sup. Ct. App. Div. 3d Dep't Dec. 13, 1984). In contrast, however, Transportation Insurance Co. v. Maksyn, 580 S.W.2d 334 (Tex. 1979), held that the Texas Workers' Compensation Law "drew its line for compensability for occupational diseases by limiting coverage to those cases in which physical activities cause harm or injury and by denying coverage when mental activities cause the harm or injury." Id. at 338. In other states, compensation may depend on whether the on-the-job stress was caused by a one-time incident rather than a prolonged stressful situation. Compare Followill v. Emerson Electric Co., 234 Kan. 791 (1984) (Kansas Workers' Compensation Act does not extend coverage to a disability caused by post-traumatic stress disorder resulting from a single on-the-job accident in which claimant suffers no physical injury) with Todd v. Goostree, 493 S.W.2d 411 (Mo. Ct. App. 1973) (holding that a neurotic disability caused by a one-time emotional shock is a compensable "injury" within the statutory definition of the Missouri Workers' Compensation Law).

II. STATE-MANDATED BENEFIT LAWS, THOUGH AFFECTING A SUBJECT OF MANDATORY COLLECTIVE BARGAINING, ARE NOT PREEMPTED BY FEDERAL LABOR POLICY.

State laws mandating the inclusion of certain benefits in collectively bargained group health insurance contracts are not preempted by federal labor law or policy. Appellants do not find the sweeping preemption they urge in any federal labor statute; nor do they contend that a finding of preemption is necessary to preserve the primacy of the National Labor Relations Board's jurisdiction in the labor-management field. Rather, appellants maintain that since employee benefits are a compulsory subject for collective bargaining, state-mandated benefit laws are an intrusion into an area which federal labor policy requires be unregulated and left entirely to the free play of economic forces.

In Malone v. White Motor Corp., 435 U.S. 497 (1978), this Court confronted

a similar claim that federal labor policy required preemption of the Minnesota Pension Act which established minimum funding and vesting standards for employee pensions. The plaintiff-employers asserted that the state statute was preempted because it imposed on them financial obligations which, by the express terms of a collective bargaining agreement, they were not required to assume. Id. at 502. The Court rejected the notion that merely because they are a subject of compulsory bargaining, pension benefits are therefore placed beyond the lawful reach of state regulation:

> There is little doubt that under the federal statutes governing labor-management relations, an employer must bargain about wages, hours, and working conditions and that pension benefits are proper subjects of compulsory bargaining. But there is nothing in the NLRA . . . which expressly forecloses all state regulatory power with respect to those issues, such as pension plans,

that may be the subject of collective bargaining.

Id. at 504-05. The Court concluded that a congressional intent to preempt state legislation regulating pension plans could not be implied from the federal labor statutes. Id. at 505.[18]

The extension of the doctrine of labor law preemption which appellants seek would prohibit state regulation of any matters affecting, however remotely, subjects of mandatory collective bargaining. This narrow view of state authority was rejected by this Court over forty years ago in Terminal Railroad Association v.

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[18] The Court went on to find a contrary congressional intent --- to permit state regulation --- evident in the enactment of the Federal Welfare and Pension Plans Disclosure Act. 29 U.S.C. §§ 301 et seq. (repealed 1974). Thus, it was the Court's conclusion in Malone that nothing intrinsic to the history of the enactment of federal labor statutes compels preemption of state regulation. But cf. Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 526 and n.23 (1981).

Brotherhood of Railroad Trainmen, 318 U.S. 1 (1943). At issue in that case was a state regulation requiring the company to provide cabooses on its trains. The employer, who was subject to the Railway Labor Act, maintained that the regulation was preempted since the presence of cabooses was a working condition and thus a mandatory subject of collective bargaining. The Court did not find a state's regulation of minimum standards of working conditions to be an interference with federal labor objectives. In upholding the state's regulatory authority, the Court explained:

> The Railway Labor Act, like the National Labor Relations Act, does not undertake governmental regulation of wages, hours or working conditions. Instead it seeks to provide a means by which agreement may be reached with respect to them. The national interest expressed by those acts is not primarily in the working conditions as such. . . .
>
> State laws have long regulated a great variety of

> conditions in transportation and industry, such as sanitary facilities and conditions, safety devices and protections, purity of water supply, fire protection, and innumerable others. . . . It cannot be that the minimum requirments laid down by state authority are all set aside. We hold that the enactment by Congress of the Railway Labor Act was not a preemption of the field of regulating working conditions themselves and did not preclude the State . . . from making the order in question.

Id. at 6-7 (footnote omitted). See also Industrial Welfare Commission v. Superior Court, 27 Cal. 3d 690, appeal dismissed, 449 U.S. 1029 (1980) (federal labor laws do not preempt state regulations establishing minimum wages, maximum hours, or standard conditions of employment); Baltimore & Ohio Railroad v. Department of Labor, 334 A.2d 636 (Pa.), appeal dismissed, 423 U.S. 806 (1975) (no preemption by the Railway Labor Act of state statute requiring railroads to pay employees weekly).

That a matter is a subject for mandatory collective bargaining does not preclude the states from adopting minimum standards below which the terms of a collective bargaining agreement may not go. Although wages, hours and occupational health and safety standards are subjects for mandatory collective bargaining, states have adopted numerous requirements setting minimum standards for each.[19] Rather than

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[19] "States possess broad authority under their police powers to regulate the employment relationship to protect workers within the state. Child labor laws, minimum and other wage laws, laws affecting occupational health and safety, and workmen's compensation laws are only a few examples." DeCanas v. Bica, 424 U.S. 351, 356 (1976). See, e.g., Cal. Lab. Code § 850 (West 1971) (maximum hours and days for persons who sell or compound drugs and medicines); Cal. Lab. Code § 1171 et seq. (West 1971 and Supp. 1984) (authorizing state Industrial Welfare Commission to set minimum standards for wages, hours and working conditions); N.Y. Lab. Law § 190 et seq. (McKinney Supp. 1984-85) (frequency and methods of paying wages); N.Y. Transp. L. § 211 (McKinney Supp. 1984-85) (maximum hours for truck and bus drivers); N.Y. Lab. Law § 240 et seq. (McKinney 1965 and Supp. 1984-85) (workplace safety standards).

leaving these subjects to the free play of economic forces, Congress has enacted legislation setting minimum standards and has, in certain instances, specifically authorized the states to adopt still more protective regulations for the benefit of employees.[20]

Federal labor policy does not require that the states be confined to a more restricted role with respect to health insurance benefits than with respect to other subjects of mandatory bargaining. The contention that if an employer is required to purchase state-mandated insurance coverage there is less money available for wages and other benefits is no less true of state regulation which may compel an employer to

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[20] For example, both the Fair Labor Standards Act of 1938 and the Occupational Safety and Health Act of 1970 authorize the states to adopt more protective regulations for the benefit of employees. 29 U.S.C. § 218 (1975); 29 U.S.C. §§ 651(b)(11), 667 (1975).

hire additional workers to comply with maximum hour restrictions or to install particular safety equipment to satisfy occupational safety requirements. The setting of minimum standards does not dictate the outcome of the bargaining process or interfere with the objectives of the federal labor laws.

III. STATE-MANDATED BENEFIT LAWS ARE PART OF THE REGULATION OF THE "BUSINESS OF INSURANCE" LEFT TO THE STATES BY CONGRESS IN THE MCCARRAN-FERGUSON ACT.

The court below recognized that "[t]he McCarran-Ferguson Act [15 U.S.C. § 1011 et seq.] establishes a congressional policy in favor of State regulation of insurance." Attorney General v. Travelers Insurance Co., 385 Mass. 598, 613-14 (1982). Congressional deference to state regulation of insurance bears upon both appellants' contention of ERISA preemption and their contention of federal labor law preemption.

The McCarran-Ferguson Act provides, in relevant part:

> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any state for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance.

15 U.S.C. § 1012(b).

Although the McCarran-Ferguson Act did not define the term "business of insurance," this Court has repeatedly emphasized that the "business of insurance" which is left to state regulation includes state laws regulating the relationship between the company and the insured:

> The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement - these were the core of the "business of insurance:" . . . whatever the exact scope of the statutory term, it is clear where the focus was - it was on the relationship between the insurance company and the policyholder. Statutes

> aimed at protecting or regulating this relationship, directly or indirectly are laws regulating the "business of insurance."

Securities and Exchange Commission v. National Securities, Inc., 393 U.S. 453, 460 (1969) (emphasis supplied). The Court has identified three criteria relevant to determining whether a particular practice is part of the "business of insurance":

> first, whether the practice has the effect of transferring or spreading a policy-holder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry.

Union Labor Life Insurance Co. v. Pireno, 458 U.S. 119, 129 (1982). State-mandated benefit laws regulate the "business of insurance" as defined by this Court and constitute the exercise of a power specifically reserved to the states. This is

illustrated by the state-mandated benefit that coverage of newborns begin from the moment of birth.

Mandatory coverage of newborns unquestionably has the effect of spreading the risk of potentially catastrophic expenses of neonatal medical treatment. J.A. 346, 454-55. There can be little doubt that the benefits provided are an integral part of the policy relationship between insurer and insured. Although the scope of benefits is integral to that relationship, it was often only after families incurred ruinous expenses for the care of a congenitally ill child that the insured learned that the coverage relied upon simply was not there because of policy exclusions. J.A. 346, 361, 387, 390, 454-55. Finally, statutes mandating benefits to be included in insurance policies are limited to entities within the insurance industry.[21]

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[21] See generally Schulkind, supra at 209-10.

The McCarran-Ferguson Act's protection of state regulation of the business of insurance is significant in interpreting both the scope of preemption intended by ERISA and the proper role for state-mandated insurance coverage in the collective bargaining process.

Section 514(d) instructed that ERISA was not to "be construed to alter, modify, invalidate, impair, or supersede any laws of the United States," 29 U.S.C. § 1144(d), including, but obviously not limited to, the McCarran-Ferguson Act. Congress surely did not intend to impair the power of the states, reenforced by federal law, to regulate the relationship between the insurer and the insured. There is no basis for suggesting that a narrower meaning is to be attributed to a "law . . . which regulates insurance," 29 U.S.C. § 1144(b)(2)(A) than this Court has given to a "law enacted . . . for the purpose of

regulating the business of insurance," 15 U.S.C. § 1012(b). Were this so, ERISA would certainly "alter, modify, invalidate, impair, or supersede" the McCarran-Ferguson Act.

The McCarran-Ferguson Act's endorsement of state regulation of insurance provides some insight into Congress' intentions. As this Court observed in Malone, the federal labor statutes do not evidence an intent on the part of Congress to preclude state legislation that affects employee benefits. By contrast, in the McCarran-Ferguson Act, Congress manifested an intent to preserve the power of the states to regulate insurance, including the power to regulate the contents of insurance policies. Congress' demonstrated interest in preserving state insurance regulation is "a far more reliable indicium of congressional intent" with respect to the power of the states to mandate insurance coverage,

including coverage purchased to satisfy contractual obligations resulting from collective bargaining. Malone, 435 U.S. at 505.[22]

CONCLUSION

For the foregoing reasons, the American Public Health Association, the American Academy of Pediatrics, and SKIP of New York, Inc. most respectfully urge this Court to affirm the decision of the Supreme Judicial Court of Massachusetts.

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[22] The parallelism between § 10 of the Federal Welfare and Pension Plans Disclosure Act, 29 U.S.C. §§ 301 et seq. (repeated 1974), and the McCarran-Ferguson Act extends further. In both acts, Congress recognized that state regulation was not static and sought to preserve not only existing state law, but "future" enactments as well. Compare Malone, 435 U.S. at 510-11 with Prudential Ins. Co. v. Benjamin, 328 U.S. 408, 431 (1946).

Dated: January 25, 1985

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TABLE I

MANDATED NEWBORN COVERAGE

These states require coverage of infants to begin at the moment of birth.

ENACTED	STATE	CITATION
1971	CA	Cal. Ins. Code §10119 (West 1972)
1973	LA	La. Rev. Stat. Ann. §22:215(A).1 (West Supp. 1984)
1973	TX	Tex. Ins. Code Ann. art. 3.70-2(E) (Vernon 1981)
1973	MN	Minn. Stat. §62A.042 (Supp. 1984)
1973	NC	N.C. Gen. Stat. §58-251.4 (1982)
1974	MA	Mass. Gen. Laws Ann. ch. 175, §47C (West Supp. 1984)
1974	OH	Ohio Rev. Code Ann. §3923.26 (Page Supp. 1984)

ENACTED	STATE	CITATION
1974	GA	Ga. Code Ann. §33-24-22 (1982)
1974	AZ	Ariz. Rev. Stat. Ann. §20-1402(2) (Supp. 1984)
1974	TN	Tenn. Code Ann. §56-7-1001 (Supp. 1984)
1974	MS	Miss. Code Ann. §83-9-33 (Supp. 1984)
1974	DE	Del. Code Ann. tit. 18, §3510 (Supp. 1984)
1974	MD	Md. Ins. Code Ann. §48A:438A (1979)
1974	HI	Hawaii Rev. Stat. §431-454 (1976)
1974	CT	Conn. Gen. Stat. Ann. §38-174g (West Supp. 1984)
1974	FL	Fla. Stat. Ann. §627.6575 (West 1984)
1974	SC	S.C. Code Ann. §38-35-70 (Law. Co-op. 1977)

ENACTED	STATE	CITATION
1974	KS	Kan. Stat. Ann. §40-2102 (1983)
1974	MO	Mo. Ann. Stat. §376.406 (Vernon Supp. 1985)
1974	MT	Mont. Code Ann. §33-22-504 (1983)
1974	WA	Wash. Rev. Code §48.21.155 (Supp. 1984)
1975	UT	Utah Code Ann. §31-20-2(5) (Supp. 1983)
1975	AL	Ala. Code §27-19-38 (1977)
1975	IL	Ill. Ann. Stat. ch. 73, §968c (Smith-Hurd Supp. 1984)
1975	WV	W. Va. Code §33-6-32 (1982)
1975	VT	Vt. Stat. Ann. tit. 8, §4090 (1981)
1975	VA	Va. Code §38.1-348.6 (1984)
1975	WY	Wyo. Stat. §26-20-101 (1984)

ENACTED	STATE	CITATION
1975	NH	N.H. Rev. Stat. Ann. §415:22 (1983)
1975	NJ	N.J. Stat. Ann. §17B:27-30 (West Supp. 1984)
1975	NM	N.M. Stat. Ann. §59-22-34 (1984)
1975	AK	Alaska Stat. §21.42.345 (1983)
1975	IN	Ind. Code §27-8-5.6-2 (Supp. 1983)
1975	CO	Colo. Rev. Stat. §10-8-121 (Supp. 1984)
1975	AR	Ark. Stat. Ann. §66-3248 (Supp. 1983), 66-3250 (1983)
1975	NV	Nev. Rev. Stat. §689B.033 (1983)
1975	IA	Iowa Code Ann. §514c.1(West) (Supp. 1984)
1975	NE	Neb. Rev. Stat. §44-710.19 (1978)
1975	PA	40 Pa. Cons. Stat. §772 (Supp. 1984)

ENACTED	STATE	CITATION
1975	OR	Or. Rev. Stat. §743.120 (1981)
1975	OK	Okla. Stat. tit. 36, §6058 (1976)
1975	MI	Mich. Comp. Laws Ann. §500.3611 (West 1983)
1975	WI	Wis. Stat. §632.895 (Supp. 1984)
1976	KY	Ky. Rev. Stat. §304.18-032 (1981)
1976	ME	Me. Rev. Stat. Ann. tit. 24-A, §2834 (Supp. 1984)
1977	NY	N.Y. Ins. Law §221(5)(a)(McKinney Supp. 1984)
1977	SD	S.D. Codified Laws Ann. §58-18-32 (Supp. 1984)
1977	ID	Idaho Code §41-2210 (1977)
1978	RI	Ins. Dept. Reg XXIII, Part IV
1979	ND	N.D. Cent. Code §26-03-38.1 (Supp. 1983)

ENACTED	STATE	CITATION
1979	DC	D.C. Code Ann. §35-1101 (1981) (Supp. 1983)

TABLE II

MENTALLY AND/OR PHYSICALLY HANDICAPPED DEPENDENTS

These laws required that coverage under an insurance policy continue beyond any age limitation (usually 19 years) for dependents who are incapable of self-sustaining employment because of mental or physical handicap and who are chiefly dependent upon the subscriber for support.

ENACTED	STATE	CITATION
1956	MA	Mass. Gen. Laws Ann. ch. 175, §108-2(3) (West Supp. 1984)
1965	NY	N.Y. Ins. Law §221(5)(a) (McKinney Supp. 1984)
1966	MI	Mich. Comp. Laws Ann. §500.2264 (West 1983)
1966	NJ	N.J. Stat. Ann. §17B:27-30 (West Supp. 1984)
1967	MO	Mo. Ann. Stat. §376.776 (Vernon 1968)
1967	IL	Ill. Ann. Stat. Ch. 73, §979b (Smith-Hurd Supp. 1984)

ENACTED	STATE	CITATION
1968	PA	40 Pa. Cons. Stat. §756.2(6) (1970)
1968	HI	Hawaii Rev. Stat. §431-452 (1976)
1968	VA	Va. Code §38.1-348.1 (1981)
1969	MN	Minn. Stat. §62A.14 (Supp. 1984)
1969	WA	Wash. Rev. Code §48.21.150 (Supp. 1984)
1969	NM	N.M. Stat. Ann. §59-18-20 §59A-22-33 (1984)
1969	TN	Tenn. Code Ann. §56-7-1005 (Supp. 1984)
1969	IN	Ind. Code §27-8-5-10(B)(4) (1975)
1969	SD	S.D. Codified Laws Ann. §58-18-31 (1978)
1969	NH	N.H. Rev. Stat. Ann. §415:18V (1983)

ENACTED	STATE	CITATION
1970	SC	S.C. Code Ann. §38-35-950 (Law. Co-op. 1976)
1970	FL	Fla. Stat. Ann. §627.6615 (West) (1984)
1971	OH	Ohio Rev. Code Ann. §3923.24 (Page Supp. 1984)
1971	WY	Wyo. Stat. §26-22-401 (1984)
1971	CA	Cal. Ins. Code §10118 (West) (1972)
1971	CT	Conn. Gen. Stat. Ann. §174e (West Supp. 1984)
1971	MT	Mont. Code Ann. §33-22-506 (1983)
1971	TX	Tex. Ins.Code Ann. art. 3.70-2(c) (Vernon 1981)
1972	ID	Idaho Code §41-2203(4) (1977)
1972	GA	Ga. Code Ann. §33-24-28 (1982)

ENACTED	STATE	CITATION
1973	LA	La. Rev. Stat. Ann. §22:215.2 (West Supp. 1984)
1973	NC	N.C. Gen. Stat. §§58-251.5, 58-251.3 (1982)
1973	NV	Nev. Rev. Stat. §689B.035 (1983)
1974	UT	Utah Code Ann. §31-20-2(4) (Supp. 1983)
1975	AR	Ark. Stat. Ann. §66-3702(4) (Supp. 1983)
1975	VT	Vt. Stat. Ann. tit. 8, §4090 (1984)
1975	WI	Wis. Stat. §632.88 (1980)
1976	NE	Neb. Rev. Stat. §44-761(4) (1978)
1977	MD	Md. Ins. Code Ann. §48A:471(7) (1979)
1977	AZ	Ariz. Rev. Stat. Ann. §20-1407 (Supp. 1984)
1983	ND	N.D. Cent. Code §26-03.6-04 (Supp. 1983)

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METROPOLITAN LIFE INSURANCE COMPANY, APPELLANT

v.

COMMONWEALTH OF MASSACHUSETTS

ON APPEAL FROM THE SUPREME JUDICIAL COURT FOR THE COMMONWEALTH OF MASSACHUSETTS

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REPLY BRIEF FOR APPELLANT

As the Commonwealth concedes, its construction of the insurance savings clause would enable states to dictate the entire benefit package to be provided by insured ERISA plans. In pressing this extreme position, appellee has downplayed ERISA's broad preemption clause, misinterpreted the statute's legislative history, misread this Court's decisions in *Alessi* and *Shaw*, and mischaracterized Section 47B. We consider each of these deficiencies in turn.

I. NEITHER THE LANGUAGE OF THE PREEMPTION AND SAVINGS CLAUSES NOR THE LEGISLATIVE HISTORY OF ERISA SUPPORTS APPELLEE'S POSITION

Appellee begins by acknowledging that ERISA's preemption clause and the insurance savings clause "must be read together to give the entire statute meaning" (Br. 14).[1] It then proceeds, however, to ignore its own admonition and to treat this case as if it could be resolved by reference to the savings clause alone. But the meaning of that clause can only be understood in the statutory context in which it is found.

A. The Statutory Language

Appellee asserts that Congress historically has left insurance regulation to the states and that in enacting ERISA Congress "made a conscious policy decision to allow the states to continue to regulate insurance" (Br. 10; see also *id.* at 12, 13, 15-17). As if mere recitation of the language of the savings clause were dispositive, appellee stresses that the statutory text "makes it clear that no intent to preempt state insurance laws exists" (Br. 14). But all this merely begs the question to be decided. The issue is not whether Congress sought to preserve state regulation of insurance but how the savings clause, which expresses that intent, should be read together with ERISA's broad preemption clause, which

[1] "Br." refers to the Brief for Appellee in this Court.

clearly reflects a congressional decision not to cede regulation of ERISA plans to the states.

Appellee's contention that its position is supported by the "plain meaning" of the savings clause is incorrect. Even if the clause were read in a vacuum, it would not be at all "plain" that it covers Section 47B. The state law was intended not to regulate insurance but to improve access to private mental health care and thus to relieve the Commonwealth from "the financial burden of solving mental health problems" (Br. 6). As accurately described in the Commonwealth's brief, Section 47B "implements a broad public policy with respect to treatment of mental illness * * *;" its purpose is "to improve the perceived inadequacies of [that] treatment" (Br. 37). Moreover, mandated benefit statutes, such as Section 47B, did not even exist in 1970, when the savings clause first appeared in bill form. See Metropolitan Br. 37. There is nothing "plain" about the savings clause's applicability to such state laws.

In any event, one portion of a single subsection of a comprehensive federal statute should not be read in a vacuum. This Court has often held that arguments based on the purported meaning of a few statutory words viewed in isolation must not be permitted to overcome the policy and purpose of an entire act. See, *e.g.*, *United States* v. *American Trucking Associations*, 310 U.S. 534, 543-544 (1940); *Ozawa* v. *United States*, 260 U.S. 178, 194 (1922); *Holy Trinity Church* v. *United States*, 143 U.S. 457, 459 (1892). Here, appellee would have the Court focus on a single word, "insurance." With total disregard for what Congress sought to accomplish in ERISA, appellee would define that word in a way that defeats the legislative purpose.

Appellee's effort to rely on the language of ERISA's "deemer clause" is similarly flawed. Appellee says that Congress enacted the deemer clause because it recognizd that the savings clause is "extremely broad"—so broad that in the absence of the deemer clause it would "swallow up the rule of general preemption and allow the states to

directly regulate employee benefit plans" (Br. 16). Appellee then argues that the deemer clause is the only explicit limitation on the savings clause and that, while it forbids direct regulation of ERISA plans, it permits states to achieve the same results indirectly, by prescribing the content of insurance policies.

Appellee thus suggests that in enacting ERISA Congress employed a highly peculiar and self-defeating method of legislative drafting—first preempting state regulation, then adopting an exception that would swallow the rule, and then adopting a further qualification that would permit the rule to be overcome indirectly but not directly. This extraordinary construction is not supported by any legislative history or by any argument concerning statutory purpose. Much more plausible is appellants' straightforward position: Congress intended broadly to preempt state regulation of ERISA plans, it never conceived that state regulation of insurance practices would interfere with that purpose, and it enacted the deemer clause just to make certain that states would not attempt to treat ERISA plans as insurers and thus circumvent the broad preemption scheme.

B. ERISA's Pre-enactment Legislative History

As previously noted (Metropolitan Br. 13-15), the single most important piece of legislative history relevant to this case is the 1974 Conference Committee decision to replace earlier, narrower versions of ERISA's preemption provision with the unusually broad provision now found in Section 514(a) of the Act. As Representative Dent explained, Congress sought "to foreclose any non-Federal regulation of employee benefit plans." 120 Cong. Rec. 29197 (1974).

Appellee now offers three responses to this legislative history. First, appellee says that if ERISA's broad preemption provision were construed in accordance with Representative Dent's remarks, it would render the savings clause meaningless (Br. 21-22; see also *id.* at 20). That is not so. A great many state laws, including laws that

regulate insurance, banking, or securities, "relate to" ERISA plans within the meaning of Section 514(a). As this Court has held, the words "relate to" are to be construed in their broad sense, to include any state law that "has a connection with or reference to" an ERISA plan. *Shaw* v. *Delta Air Lines*, 103 S.Ct. 2890, 2900 (1933). Numerous state laws that genuinely regulate insurance also "relate to" ERISA plans in this broad sense and are protected from preemption by the savings clause. See Metropolitan Br. 34-36.

That does not mean, however, that the savings clause allows "non-Federal regulation" of ERISA plans, in the sense that Representative Dent used the phrase. Congress did not view the savings clause as a subterfuge by which states could regulate ERISA plans. It viewed the clause simply as a means of preserving traditional forms of state regulation in the areas of insurance, banking, and securities—regulation that might have some peripheral impact on ERISA plans (and thus fall within the scope of Section 514(a)) but that would not interfere with the congressional purpose of leaving the substantive content of such plans to private determination. Appellants' construction of the preemption and savings clauses thus accords with congressional intent and at the same time gives vitality to both stat tory provisions.

Appellee's second response to the Conference Committee's broadening of ERISA's preemption provision is that it did not "narrow[] or obviate[]" the savings clause (Br. 24; see also *id.* at 21). But, of course, appellants have never contended that it did. Indeed, appellants expressly noted (Metropolitan Br. 37) that, from 1970 on, the savings clause was included, in virtually identical form, in all of ERISA's predecessor bills. The important point is not the constancy of the clause's language but the fact that it must be read together with the preemption provision that it qualifies.

Before the preemption clause was broadened, it did not cover Section 47B, because Section 47B did not relate to any of the specific subjects that were to be regulated by

ERISA. Accordingly, before the Conference Committee's action, there would have been no need to determine whether Section 47B is a state law that regulates insurance within the meaning of the savings clause. The statute would not have been preempted in any event. That is why the breadth of ERISA's preemption provision is highly relevant. By including all state laws that relate to ERISA plans, Congress made it necessary to construe the savings clause in a way that would not defeat Congress' broad preemptive purpose.

Third, appellee seeks to restrict the significance of ERISA's broad preemption provision by referring to one example of potential state interference with ERISA plans that specifically attracted Congress' attention in 1974 (Br. 22-23). Congress was concerned that states not attempt to regulate the legal services an ERISA plan may provide.[2] Senator Williams and Representative Dent merely used such potential state regulation as an example of the kind of state control that would be precluded by ERISA's broad preemption clause. The example illustrates the breadth of the preemption; it does not narrow it.[3]

C. ERISA's Post-enactment Legislative History

Appellee attempts to derive support from two pieces of post-enactment legislative history (Br. 24-27).[4] The

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[2] Prepaid legal services are one of the benefits that an ERISA plan may provide. They are mentioned explicitly in the definition of "employee welfare benefit plan" in Section 3(1) of the Act, 29 U.S.C. 1002(1).

[3] If appellee were to prevail here, the states could use so-called "insurance" laws to regulate the prepaid legal services provided by insured ERISA plans—precisely the kind of regulation that Congress sought to prohibit.

[4] This Court has held that subsequent legislative developments are of minimal value (at most) in statutory interpretation. "[T]he views of a subsequent Congress form a hazardous basis for inferring the intent of an earlier one," particularly when the subsequent legislative events involve something less than enactment of a statute. *United States* v. *Price*, 361 U.S. 304, 313 (1960). See also

first is an oversight report prepared by Representative Dent's Subcommittee on Labor Standards during the Congress after ERISA was enacted. Activity Report of the House Comm. on Education and Labor, H.R. Rep. No. 1785, 94th Cong., 2d Sess. (1977). Appellee has misused the report, quoting an excerpt that has no bearing on the present case and failing to quote the material that does illumine the reasons for ERISA's broad preemption provision.

The passage on which appellee seeks to rely (Br. 25) only concerns entrepreneurs who functioned as insurers but sought to insulate themselves from state regulation by calling their enterprises ERISA plans.[5] The oversight committee merely endorsed the obvious conclusion that ERISA does not permit such an abuse. Contrary to appellee's assertion (Br. 25), the report says nothing about state regulation of insurance products purchased by ERISA plans.

The oversight report does provide useful insight into the rationale of ERISA's preemption provision. In an extended discussion, most of which is reproduced in the amicus brief of the AFL-CIO (at 21-23), Representative Dent's subcommittee explained that Congress acted "deliberately to preclude state authority over [ERISA] plans" and "to insure uniformity of regulation with respect to their activities." H.R. Rep. No. 1785, *supra*, at 46. The congressional policy was "the creation of uniform national standards," and the exceptions to preemption were not intended to detract from that goal. Rather, they were "designed to save state law as it is applied to entities which are not employee benefit plans * * *, to the extent that such regulation does not relate to employee benefit plans." *Ibid.* ERISA plans "needed to be freed of the possibility of state regulation," but at the same

Consumer Product Safety Commission v. *GTE Sylvania, Inc.*, 447 U.S. 102, 118 n.13 (1980); *Southeastern Community College* v. *Davis*, 442 U.S. 397, 411 n.11 (1979).

[5] The abusive practice is described in detail in *Bell* v. *Employee Security Benefit Association*, 437 F. Supp. 382 (D. Kan. 1977).

time Congress sought "to avoid disrupting state efforts to regulate the conduct of other financial entities not subject to the federal Act." *Ibid.* Summarizing its conclusions, the subcommittee stated (*id.* at 47):

> Based on our examination of the effects of section 514, it is our judgment that the legislative scheme of ERISA is sufficiently broad to leave no room for effective state regulation within the field preempted. Similarly it is our belief that the Federal interest and the need for national uniformity are so great that enforcement of state regulation should be precluded.

The oversight report thus reaffirms that ERISA's preemption provision was intended to enable employers to maintain uniform multistate ERISA plans and that the narrow exceptions to preemption were not intended to reinstate the very state authority that Congress sought to preclude.

The second piece of post-enactment history on which appellee relies is a proposed 1979 amendment to ERISA's savings clause. S. 209, 96th Cong., 1st Sess. § 155 (1979), reprinted in 125 Cong. Rec. 933, 937 (1979). The unenacted amendment would have overruled *Wadsworth* v. *Whaland*, 562 F.2d 70 (1st Cir. 1977), cert. denied, 435 U.S. 980 (1978), and made clear that mandated benefits statutes are not laws that regulate insurance within the meaning of ERISA. Appellee's reliance on this bill is misplaced.

As this Court has frequently held, unsuccessful amendments are unreliable guides to statutory interpretation. "Logically, several equally tenable inferences could be drawn from the failure of the Congress to adopt an amendment in light of the interpretation placed upon the existing law by some of its members, including the inference that the existing legislation already incorporated the offered change." *United States* v. *Wise*, 370 U.S. 405, 411 (1962).[6] The ambiguity is particularly great when

[6] See also, in addition to the cases cited in *Wise*, *United States* v. *W.M. Webb, Inc.*, 397 U.S. 179, 194 n.21 (1970); *Commissioner* v.

an amendment is introduced in response to a judicial decision that has reached a contrary result. In that situation, the proposed amendment may well be intended to correct the court and not the statute.

If the introduction of a proposed amendment were to be interpreted as an acknowledgment that the existing statute, properly interpreted, leads to the opposite result, members of Congress, the Executive Branch, and the public would be discouraged from seeking to clarify disputed statutory points. See *Wong Yang Sung* v. *McGrath*, 339 U.S. 33, 47 (1950), in which this Court rejected an argument very much like the one advanced here by appellee.

In short, the unsuccessful 1979 amendment leaves this controversy precisely where it would have been had the amendment not been introduced.

II. APPELLEE MISREADS THIS COURT'S DECISIONS IN *SHAW* AND *ALESSI*

The principal relevant teaching of *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981), is that state regulation of ERISA plans is preempted whether the regulation is direct or indirect. The principal relevant teaching of *Shaw* v. *Delta Air Lines*, 103 S.Ct. 2890 (1983), is that ERISA preemption does not require a conflict between state law and the federal statute. Both of these holdings are ignored in appellee's brief. Instead, appellee cites *Alessi* and *Shaw* for several propositions that the cases either do not support or flatly contradict.

First, appellee says that *Alessi* and *Shaw* both confirm a presumption against ERISA preemption (Br. 17). That is not correct. *Alessi* recites the general rule that preemption is disfavored in the absence of a clear statement from Congress, but it holds that Section 514(a) is just such an "explicit congressional statement." 451 U.S. at 522-523. *Shaw* does not say anything at all about a

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Engle, 104 S. Ct. 597, 607 n.21 (1984); *Order of Railway Conductors* v. *Swan*, 329 U.S. 520, 529 (1947); *Red Lion Broadcasting Co.* v. *FCC*, 395 U.S. 367, 381 n.11 (1969).

presumption against preemption. It simply holds that the language of Section 514(a) is unusually broad and reflects the congressional intent to foreclose state regulation. 103 S.Ct. 2899-2901.

Second, appellee tries to blunt the impact of *Alessi* by arguing that the New Jersey law at issue there was held to be preempted because it prohibited a practice that "ERISA explicitly permits" (Br. 17). Once again, appellee's statement is inaccurate. As this Court noted, "ERISA does not mention integration with workers' compensation, and the legislative history is equally silent on this point." 451 U.S. at 517.

Third, appellee contends (Br. 19) that *Shaw* "strongly intimated" that the Commonwealth's reading of the savings clause is correct. Appellee says that this Court "compared and contrasted the extremely broad scope of § 514(b), the savings clause * * *, with the narrow exemption worked by § 514(d)," the subsection at issue in *Shaw*. This statement is completely false. Section 514(b) is mentioned exactly once on the pages of the *Shaw* opinion cited by the Commonwealth. 103 S. Ct. at 2903-2904 (cited in Br. 19). This is the full sentence: "Sections 4(b)(3) and 514(b), which list specific exceptions, do not refer to state fair employment laws." 103 S.Ct. at 2903. That is all. There is no suggestion that the preemption exception in Section 514(b) is "extremely broad" or is broader than the one in Section 514(d). On the contrary, the sentences before and after the sentence just quoted make clear that the Court considered *all* the exceptions to ERISA preemption to be narrow. In the Court's words, "Congress * * * creat[ed] only very limited exceptions to pre-emption." 103 S.Ct. at 2903. Congress combined "enactment of an all-inclusive pre-emption provision" with "enumeration of narrow, specific exceptions to that provision." *Id.* The context thus makes clear that Section 514(b) is one of the "narrow, specific exceptions."

Fourth, referring to *Shaw*'s treatment of the New York Disability Benefits Law, appellee asserts (Br. 19) that "the Court noted its approval of a statutory scheme that would indirectly dictate the contents of an ERISA plan

and thereby detract from the uniformity of multi-state benefit plans." Once more, the Commonwealth is wrong. *Shaw* expressly held that states may *not* compel ERISA plans to contain certain disability benefits. 103 S.Ct. at 2906 ("the States may not require an employer to alter its ERISA plan"). At most, states may require employers to maintain separate plans solely for the purpose of complying with state disability insurance laws. Under Section 4(b)(3) of ERISA, 29 U.S.C. 1003(b)(3), such separate plans are not ERISA plans at all; ERISA simply does not apply to them. By refusing to permit states to compel employers to include disability benefits in their ERISA plans, *Shaw* sought to ensure that the variation among state disability benefits laws would not preclude multistate employers from maintaining a uniform ERISA plan.[7]

Doubtless as the result of its failure to appreciate the significance of *Alessi* and *Shaw*, the Commonwealth relies heavily (Br. 20-21, 26, 32) on the federal government's submission in *Wadsworth* v. *Whaland*, 562 F.2d 70 (1st Cir. 1977), cert. denied, 435 U.S. 980 (1978) (Nos. 77-765 and 77-772). The government's seven-year-old memorandum, which was prepared before *Alessi* and *Shaw* were decided, reflects neither the breadth of ERISA's preemption clause nor the congressional purposes that underlie the statutory scheme.

Given the changes in circumstances and the government's failure to file a brief in this case, no inference can be drawn concerning the government's position, and its earlier brief should not be treated as one filed now. If

[7] The Commonwealth therefore is wrong in asserting (Br. 33) that differences among state workers' compensation laws and disability laws prevent uniformity of multistate ERISA plans. Section 4(b)(3) of ERISA shows that when Congress wished to permit state prescription of benefits, it did so expressly, outside the scope of ERISA, in a manner designed not to interfere with employers' and employees' statutory right to a uniform ERISA plan. Section 4(b)(3) expressly refers to both workers' compensation laws and disability laws, but it has nothing to do with health benefit statutes like Section 47B.

inferences are to be drawn from the government's silence here, following its participation in *Wadsworth*, *Alessi*, and *Shaw*, appellants suggest that the proper inference is that the government views the matter differently today than it did in *Wadsworth*, but would rather not bear the burden of changing its earlier position.

III. THE McCARRAN-FERGUSON ACT DOES NOT ASSIST IN THE INTERPRETATION OF THE SAVINGS CLAUSE AND IN ANY EVENT DOES NOT SUPPORT APPELLEE'S POSITION

Several amici—but not the Commonwealth—argue that ERISA's savings clause should be construed in pari materia with the McCarran-Ferguson Act's references to "the business of insurance." Br. for American Psychological Assn., et al. 14-22; Br. for American Psychiatric Assn., et al. 7-20. Plucking isolated bits of language from decisions dealing with unrelated subjects, they further contend that, if the savings clause is so construed, it protects Section 47B from preemption.[8] Amici are wrong on both counts.[9]

[8] Amici rely primarily on three cases, two of which deal with the McCarran-Ferguson Act's antitrust exemption for "the business of insurance." *Union Labor Life Insurance Co.* v. *Pireno*, 458 U.S. 119 (1982); *Group Life & Health Insurance Co.* v. *Royal Drug Co.*, 440 U.S. 205 (1979). The third concerns the question whether a merger of two insurance companies, approved by the state insurance commissioner, is covered by the federal securities laws. *SEC* v. *National Securities, Inc.*, 393 U.S. 453 (1969). In all three, the conduct in question was held not to be "the business of insurance."

[9] One amicus brief makes the further contention that ERISA is not a law that "specifically relates to the business of insurance" under Section 2(b) of the McCarran-Ferguson Act, 15 U.S.C. 1012(b), and that therefore the Act prohibits ERISA from being construed "to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance * * *." Br. for American Psychological Assn., et al. 20-21 & n.24. This argument—which the Commonwealth does not make—has already been rejected by two federal courts of appeals, and we know of no contrary decisions. *Hewlett-Packard Co.* v. *Barnes*, 571 F.2d 502, 505 (9th Cir.), cert. denied, 439 U.S. 831 (1978); *Spirt* v. *Teachers Insurance and Annuity Association*, 691 F.2d 1054, 1065

A. Neither reason nor evidence suggests that ERISA and the McCarran-Ferguson Act should be construed in pari materia

The McCarran-Ferguson Act was enacted in 1945, nearly 30 years before ERISA. Its sole focus was insurance. As this Court has explained, the Act was a reaction to the decision in *United States* v. *South-Eastern Underwriters Association*, 322 U.S. 533 (1944), which held that an insurance contract is a transaction in commerce and that insurance companies doing business across state lines are thus subject to federal law. *South-Eastern Underwriters* reversed the 75-year-old decision in *Paul* v. *Virginia*, 75 U.S. (8 Wall.) 168 (1869), which had held that "[i]ssuing a policy of insurance is not a transaction of commerce" (*id.* at 183) and that therefore state laws regulating insurance were not preempted by the Commerce Clause. See *SEC* v. *National Securities, Inc.*, 393 U.S. 453, 458 (1969).

Justice Black's opinion for the Court in *South-Eastern Underwriters* summarized the origin and history of state regulation of insurance, and the practical basis of the decision in *Paul*:

> As early as 1866 the insurance trade, though still in its infancy, was subject to widespread abuses. To meet the imperative need for correction of these abuses the various state legislatures, including that of Virginia, passed regulatory legislation. *Paul* v. *Virginia* upheld one of Virginia's statutes.

322 U.S. at 544-545 (footnotes omitted). At a time when no federal laws existed to regulate the insurance business, the rationale of *Paul* was applied to uphold numer-

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(2d Cir. 1982), vacated and remanded on other grounds, 103 S. Ct. 3565 (1983). The precedents are clearly correct. ERISA is replete with explicit references to insurance and insurers, not the least of which is the savings clause at issue in this case. See, *e.g.*, 29 U.S.C. 1002(1), (38); 1023(e). Indeed, if Congress had not believed that ERISA "specifically relates to the business of insurance," the savings clause would have been unnecessary; the McCarran-Ferguson Act itself would have precluded ERISA preemption of any state law enacted "for the purpose of regulating the business of insurance."

ous other state laws regulating insurance. *Id.* at 543-544 & n.18 (citing cases).

In 1944, however, the insurance companies in *South-Eastern Underwriters* sought to use *Paul*'s holding as a shield against a criminal antitrust prosecution under the Sherman Act. This Court rejected the effort and overruled *Paul*. That called into question the validity of the large body of state insurance regulation developed since *Paul*. Congress was concerned that state regulation of out-of-state insurers might be said to intrude on the exclusive federal authority to regulate the interstate business of insurance. *SEC* v. *National Securities, Inc.*, *supra*, 393 U.S. at 458. To avert this problem, Congress passed the McCarran-Ferguson Act. The statute's purpose was to preserve the existing regime of state insurance regulation and to delineate the applicability of certain federal statutes, including the antitrust laws, to the business of insurance.

ERISA's purposes were very different. Congress' primary focus was the regulation of employee welfare and pension plans. When Congress enacted the preemption and savings clauses, it sought to remove ERISA plan regulation from the reach of state law but to leave state regulation of insurance, banking, and securities otherwise unaffected. As Rep. Dent's subcommittee said in its oversight report, "the problem was to extract [ERISA] plans from the regulatory schemes in the several states without creating untoward side effects." H.R. Rep. No. 1785, *supra*, at 46.

There is no evidence whatever that in drafting the savings clause Congress focused on the language of the McCarran-Ferguson Act or on any of the cases interpreting the Act's references to "business of insurance." Nor is there any reason why Congress should have done so. ERISA and the McCarran-Ferguson Act were intended to serve different purposes, and there is no reason why the word "insurance" in one must be coterminous with the phrase "business of insurance" in the other. As Justice Holmes wrote for the Court in *Towne* v. *Eisner*, 245 U.S. 418, 425 (1918), "A word is not a crystal,

transparent and unchanged, it is the skin of a living thought and may vary greatly in color and content according to the circumstances and the time in which it is used." Particularly in the absence of any evidence that Congress considered the McCarran-Ferguson Act, the Court should not assume that they must be construed in parallel. See *Perez* v. *Campbell*, 402 U.S. 637, 655 (1971).

This Court has interpreted the McCarran-Ferguson Act primarily in the context of the Act's antitrust exemption for the business of insurance. The Court itself has observed that interpretation of the Act in that context involves considerations different from those that would govern a case involving the Act's primary purpose—preserving the type of state regulation that was in place prior to *South-Eastern Underwriters. Group Life & Health Insurance Co.* v. *Royal Drug Co.*, 440 U.S. 205, 218 n.18 (1979). Such variation in the construction of a statutory reference to "insurance" is even more to be expected where, as here, a second—and much different—federal statute is involved. As one commentator has observed:

> Attempts have sometimes been made, in statutes and elsewhere, to formulate a general definition of insurance for use in determining the reach of these regulatory measures. The success of any such effort is bound to be limited because different regulatory measures are efforts to respond to needs of very different scope. Thus, as already noted, no single concept of insurance is universally useful as a tool of thought and communication about such problems.

R. Keeton, *Basic Text on Insurance Law* 9 (1971) (footnote omitted).

B. In Any Event, the McCarran-Ferguson Act and Cases Decided under that Statute Do Not Support Appellee's View of the Savings Clause

Even if one seeks to interpret the savings clause by reference to the McCarran-Ferguson Act, the conclusion remains that Section 47B is not protected from ERISA preemption. The state insurance laws that the McCarran-Ferguson Act sought to preserve were statutes intended

either to regulate the potentially abusive practices of insurance companies or to tax such companies' business. As the 1944-45 congressional debates show, Congress focused its attention on state regulation of ratemaking, licensing, commissions, solvency, and investments. 90 Cong. Rec. 6418-6419, 6531 (1944) (remarks of Rep. Allen and Rep. Satterfield); 91 Cong. Rec. 482-483 (1945) (remarks of Sen. Radcliffe).[10] All of these matters involve protection of the policyholder against abuses by the insurance company—just the type of state legislation that would be preserved under appellants' construction of the savings clause. Nowhere does the legislative history of the McCarran-Ferguson Act suggest any consideration of state mandated benefit laws. That is hardly surprising, since such laws were unknown at the time.[11]

The numerous state insurance laws reviewed by this Court during the years between *Paul* and *South-Eastern Underwriters* provide further evidence of the kind of regulation that Congress sought to preserve through the McCarran-Ferguson Act. Without exception, these laws involved state efforts to prevent abusive practices or to tax the business of insurance companies.[12] None of the statutes remotely resembled mandated benefits laws.

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[10] For example, Representative Allen stated, "the public interest lies primarily in the protection of the policyholders through the preservation of the financial soundness of the insurer." 90 Cong. Rec. 6419 (1944). See also *id.* at 6525 ("Forty-eight States have departments of insurance to regulate and control rates, investments, commissions, and the other details of the business for the benefit and protection of their citizens") (remarks of Rep. Hancock).

[11] By applying the label "mandated benefit statute" to any statute that deals in any way with the coverage of a health insurance policy, some amici have tried to dispute appellants' observation that no such statute appeared until 1971. Br. for the American Psychological Assn., et al. 8-11. Instead, amici contend, such statutes existed as early as 1949. Even under amici's broadened—and here irrelevant—definition of mandated benefit statutes, no such law existed until several years after the McCarran-Ferguson Act was passed. Thus, Congress could not have had such laws in mind in 1945.

[12] See, *e.g.*, *Ducat* v. *Chicago*, 77 U.S. (10 Wall.) 410 (1871) (agent licensing, capital stock and asset statements, premium tax,

In *SEC* v. *National Securities, Inc.*, 393 U.S. 453 (1969), this Court explicitly recognized that traditional state regulation of insurance focused on the cost and reliability of coverage and the fairness of insurance companies' treatment of policyholders. Protection of the policyholder from abuses by the insurer was the central feature of such laws. As the Court stated,

> [t]he McCarran-Ferguson Act was an attempt to turn back the clock, to assure that the activities of insurance companies in dealing with their policyholders would remain subject to state regulation. * * *
>
> Given this history, the language of the statute takes on a different coloration. * * * [W]hatever the exact scope of the statutory term, it is clear where the focus was—it was on the relationship between the insurance company and the policyholder. Statutes aimed at protecting or regulating this relationship, directly or indirectly, are laws regulating the business of insurance.

Id. at 459-460.

Mandated benefit statutes such as Section 47B are not "aimed at protecting or regulating th[e] relationship" between the insurance company and the policyholder. As appellee expressly acknowledges, Section 47B was enacted "to address the problem of treating mental illness in the Commonwealth" (Br. 2); it is Massachusetts' "solution to the mental health treatment problem" (Br. 4).[13] It is

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penalties, remedies); *Hooper* v. *California*, 155 U.S. 648 (1895) (bonding requirement); *New York Life Insurance Co.* v. *Cravens*, 178 U.S. 389 (1900) (nonforfeiture provision); *German Alliance Insurance Co.* v. *Lewis*, 233 U.S. 389 (1914) (public filing of rate schedules, restrictions on rate changes, commissioner's power to raise or lower rates, rate discrimination prohibition); *Bothwell* v. *Buckbee, Mears Co.*, 275 U.S. 274 (1927) (licensing, statement of financial condition, agent for service, deposit reserve).

[13] The Commonwealth's focus on *National Securities'* reference to "the type of policy which could be issued," 393 U.S. at 460, does not alter this conclusion. Before the McCarran-Ferguson Act was passed, some states required the use of standardized or uniform contracts. See, *e.g.*, *Hoopeston Canning Co.* v. *Cullen*, 318 U.S. 313

not an attempt to deal with abuses and excesses by an insurer with respect to its policyholder, and it is therefore not the kind of statute that Congress sought to preserve in the McCarran-Ferguson Act.[14]

Group Life and Health Insurance Company v. *Royal Drug Co.*, 440 U.S. 205 (1979), leads to the same conclusion. The case held that insurance company contracts with pharmacists, which concerned the price at which pharmacists would provide drugs to persons covered by health insurance policies, were not protected by the McCarran-Ferguson Act's antitrust exemption for the "business of insurance." In describing the "business of insurance," the Court focused on "the spreading and underwriting of a policy-holder's risk" and "the contract between the insurer and the insured." *Id.* at 211-217. Read in context, neither of these phrases includes the *insured's choice* of the risks for which it desires coverage. Rather, they concern the insurance company's handling of the risks that the insured asks it to assume. By enacting a law requiring insurers to offer certain protection, a state might act "for the purpose of regulating the business of insurance;" but, by requiring insureds to accept coverage they do not want—as appellee has done in Section 47B—a state acts for different social purposes, purposes that do not involve the business of insurance.

(1943) (fire insurance policy). These statutes were among those that Congress sought to preserve with the McCarran-Ferguson Act. See 90 Cong. Rec. 6535 (1944) (remarks of Rep. Gwynne); *id.* at A4406 (proposal of National Association of Insurance Commissioners). Standardization of forms is not the same thing as requiring that particular kinds of risks be covered.

[14] Throughout its brief, the Commonwealth misstates the terms of its own statute. Not only does appellee ignore the direct applicability of Section 47B to ERISA plans, but it also says repeatedly that Section 47B applies only to insurance policies issued or sold in Massachusetts (Br. 2, 4, 9, 11, 37, 39). In fact, the statute applies to all insurance policies, wherever issued, that cover residents of the Commonwealth. J.S. App. 87a-89a. It is precisely this "extra-territorial" effect of several mandated benefit statutes that poses a major problem for multistate employers seeking to maintain uniform ERISA plans.

IV. NONE OF APPELLEE'S REMAINING ARGUMENTS SUPPORTS STATE REGULATION OF THE BENEFITS PACKAGE PROVIDED BY INSURED ERISA PLANS

Appellee makes two additional arguments in support of its position that it may indirectly—yet totally—regulate the benefits package provided by an insured ERISA plan. Neither can withstand analysis.

A. The Commonwealth's Asserted Power to Regulate the Terms of Insurance Policies

The Commonwealth contends (Br. 29-30) that states have the power to "control the content of insurance policies" and that this Court has recognized as much. The Commonwealth also says that it has exercised that power, to dictate the terms of automobile insurance policies (Br. 31). Neither point is relevant to the question whether mandated benefit statutes are saved from ERISA preemption.

No one denies that, apart from ERISA, states have the power to control the terms of insurance policies issued within their borders. The question here is not one of power but of compatibility with the federal statutory scheme.

The Commonwealth's automobile insurance example is also inapposite. Automobile insurance is not among the benefits that can be offered by ERISA plans. See Section 3(1) of the Act, 29 U.S.C. 1002(1). Thus, state statutes dictating the terms of automobile insurance policies pose no threat to the autonomy of ERISA plans; they are simply irrelevant.

B. The Commonwealth's "Regulatory Vacuum Argument

Appellee and amici both contend that appellants' position will create a "regulatory vacuum" for the substantive benefits that must be provided by insurance policies sold to ERISA plans (Br. 29; Br. for American Psychiatric Assn., et al. 18-19). The point is easily answered. Until 1971, there were no mandated benefit statutes, so the "regulatory vacuum" that appellee fears was the

norm in all states.[15] Moreover, as appellants showed in their opening brief (Metropolitan Br. 27-29), Congress deliberately chose to leave the content of ERISA plans to private determination. That intent requires that insured plans remain free to buy policies that provide only the benefits they select. Otherwise, insured plans will be allowed only the degree of choice that state legislatures permit.

V. THE SELF-EVIDENT EFFECT OF MANDATED BENEFIT LAWS

Neither appellee nor any amicus has been able to overcome the self-evident proposition that mandated benefit statutes increase costs, impede uniformity, and tend to encourage self-insurance. See *Shaw* v. *Delta Air Lines*, *supra*, 103 S.Ct. at 2904 & n.25. Nor can anyone fairly dispute that this defeats the statutory purpose.[16]

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[15] As noted at pages 3-4 n.5 of our main brief and in briefs filed by several amici, various state statutes that did exist before 1970 affected certain benefits provided in health insurance policies. For example, "provider" statutes required that payments be made to a non-medical provider of a service (*e.g.*, a social worker) if they would be made to a medical provider (*e.g.*, a psychiatrist). For another example, "conversion" statutes defined an employee's rights when his employment status changed.

Neither the Commonwealth nor any amicus has disputed the statement in appellants' main brief (Metropolitan Br. 11, 37) that before 1970 there were no mandated benefit statutes, as we have defined the term: state laws that require coverage for a particular illness or condition. Since the differences among the various kinds of statutes are substantial, and since the savings clause has never before been construed by this Court, this Court's decision should not go beyond the narrow group of statutes here challenged by appellants.

[16] Some amici have suggested that there is a rationale that might have led Congress to treat insured and self-insured plans differently. Br. for American Psychiatric Assn., et al. 20 & n.8. They say that "businesses large enough to self-insure are likely to provide adequate health insurance without government regulation." Only one authority is cited for this proposition; it is a study prepared by one of the amici, and it does not support their assertion. More important, amici offer no evidence that Congress intended to distinguish between insured and self-insured plans. The statutory

The impact of statutes such as Section 47B is reflected in the identities of the amici supporting each side in this case. Appellants' position is supported by both employees and employers, the very groups that pay for and are intended to benefit from ERISA plans.[17] Not a single employee or employer group urges affirmance. The only amicus support for appellee comes from other states and from providers of health care, many of whose services mandated benefit laws seek to promote. That, we submit, is a telling lineup, particularly for a statute that the Commonwealth is trying to defend as a regulation of insurers for the benefit of the insured.

CONCLUSION

For all the foregoing reasons, as well as the reasons set forth in appellants' opening brief, the judgment of the Supreme Judicial Court should be reversed.

Respectfully submitted,

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language shows that it did not. 29 U.S.C. 1002(1). Nor can amici rationalize imposing the added costs of mandated benefit statutes disproportionately on those ERISA plans least able to afford them, *i.e.*, smaller plans for which self-insurance is not a viable option.

[17] Among the amici supporting appellants are the AFL-CIO, the ERISA Industry Committee (a nonprofit association of more than one hundred corporations maintaining welfare benefit plans for their employees), several employee health and welfare funds, and the National Coordinating Committee for Multiemployer Plans.